West Virginia

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 08/18/2015 8.00.00 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2016
End Year	2017

State SAPT DUNS Number

Number	618137715
Expiration Date	

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name	West Virginia Department of Health and Human Resources
Organizational Unit	Office of the Secretary
Mailing Address	One Davis Square, Suite 100 East
City	Charleston
Zip Code	25301

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Kathy
Last Name	Paxton
Agency Name	West Virginia Department of Health and Human Resources
Mailing Address	350 Capitol Street, Room 350
City	Charleston
Zip Code	25301
Telephone	304-356-4796
Fax	304-558-1008
Email Address	Kathy.L.Paxton@wv.gov

State CMHS DUNS Number

Number	618137715
Expiration Date	11/20/2013

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	West Virginia Department of Health and Human Resources
Organizational Unit	Office of the Secretary
Mailing Address	One Davis Square, Suite 100 East
City	Charleston
Zip Code	25301

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Peg
Last Name	Moss
Agency Name	West Virginia Department of Health and Human Resources
Mailing Address	350 Capitol Street, Room 350

City	Charleston
Zip Code	25271
Telephone	304-356-4825
Fax	304-558-1008
Email Address	peg.l.moss@wv.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

IV. Date Submitted

Submission Date	
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	
Last Name	
Telephone	
Fax	
Email Address	

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPMâ€™s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to childrenâ€™s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to childrenâ€™s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for childrenâ€™s services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Karen L. Bowling

Signature of CEO or Designee[1]: _____

Title: Cabinet Secretary

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

STATE OF WEST VIRGINIA
OFFICE OF THE GOVERNOR
1900 KANAWHA BOULEVARD, EAST
CHARLESTON, WV 25305
(304) 558-2000

EARL RAY TOMBLIN
GOVERNOR

August 9, 2013

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100 East
Charleston, West Virginia 25301

Dear Cabinet Secretary Bowling:

This letter is to authorize you in your position as Cabinet Secretary of the West Virginia Department of Health and Human Resources to serve as my designee for the purpose of signing the Substance Abuse Prevention and Treatment block grant application, certifications, waiver requests, etc.

This authorization will remain in effect until further notice.

Wish warmest regards,

Earl Ray Tomblin
Governor

Footnotes:

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State Information

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Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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as required by
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as authorized by
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Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
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The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for childrenâ€™s services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Karen L. Bowling

Signature of CEO or Designee[1]: _____

Title: Cabinet Secretary

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

STATE OF WEST VIRGINIA
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EARL RAY TOMBLIN
GOVERNOR

August 9, 2013

Karen L. Bowling, Cabinet Secretary
West Virginia Department of Health and Human Resources
One Davis Square, Suite 100, East
Charleston, West Virginia 25301

Dear Cabinet Secretary Bowling:

This letter is to authorize you in your position as Cabinet Secretary of the West Virginia Department of Health and Human Resources to serve as my designee for the purpose of signing the Mental Health Services Block Grant application, certifications, waiver requests, etc.

This authorization will remain in effect until further notice.

With warmest regards,

Earl Ray Tomblin
Governor

Footnotes:

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Governor

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name	Karen L. Bowling
Title	Cabinet Secretary
Organization	West Virginia Department of Health and Human Resources

Signature: _____ Date: _____

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

BG Step I-Assess the Strengths and Needs of the Service System to Address Specific Populations

BEHAVIORAL HEALTH SYSTEM OVERVIEW

The Bureau for Behavioral Health and Health Facilities (BBHHF) is the federally designated State Authority for mental health, substance abuse, and intellectual and developmental disabilities, and provides funding for community-based behavioral health services for persons with behavioral health needs, including those who are either uninsured or underinsured. The BBHHF operates under the auspices of the WV Department of Health and Human Resources (DHHR) which also includes the State Bureaus of Public Health (BPH), Child Welfare, and Medicaid. The overall role of the BBHHF is to provide leadership, oversight and coordination of policy, planning, development, funding and monitoring of the public behavioral health system. The principles that guide the work of the BBHHF are aligned with the Substance Abuse Mental Health Services Administration (SAMHSA) in understanding that the evidence base behind behavioral health prevention and promotion, treatment, and recovery services continues to grow and promises better outcomes for people with or at risk for mental and substance use disorders. Partnerships and collaborations among public and private systems as well as with individuals, families, agencies and communities are essential components in systems of care surrounding each person.

The Bureau includes three interrelated sections which are Operations, Programs and Policy, and Administration. Operations provides oversight and coordination of planning, development, funding, and monitoring of State-operated psychiatric hospitals for adults, long-term care facilities, and an acute care facility. Administration is responsible for fiscal management, technology and shared data systems. Programs and Policy provides oversight and coordination of planning, development, funding, and monitoring of community behavioral health services and supports.

The Programs and Policy section includes the integrated Divisions on Alcoholism and Drug Abuse, Adult Mental Health, Child and Adolescent Mental Health and Intellectual and Developmental Disabilities. The Office of Consumer Affairs and Community Outreach provide support for all divisions by promoting increased consumer and family involvement in behavioral health service planning and delivery. All division directors and their staff have significant education and real world experience supporting the provision of technical assistance and modeling best practice. These teams work closely together to make thoughtful system decisions and coordinate all planning, allocation and monitoring functions.

The *Division of Adult Mental Health* is the Single State Authority for Adult Mental Health and thereby assures and provides access to services and supports to meet the mental health and

co-occurring needs of adults and transitional age youth, enabling them to live, learn, work and participate actively in their communities. The Division's priorities include development and expansion of peer and family supports, the West Virginia Leadership Academy, recovery education, housing and homeless outreach to people with mental health issues and co-occurring addictions, and coordination and delivery of services for returning veterans and their families, integrated primary care and mental health services, and operational support for the West Virginia Mental Health Planning Council. Children and Adult Services are separately developed, identified and tracked in accordance with block grant requirements.

The *Division of Child and Adolescent Behavioral Health* is the Single State Authority for Children's Mental Health, charged with monitoring and improving the child and adolescents' mental health service delivery system. The Division provides leadership, technical assistance and funding to support children and adolescents with serious emotional disturbances and their families. The Division's overarching priority continues to focus on increasing access and building service capacity through key initiatives including, the West Virginia System of Care (WVSOC), Statewide Family Advocacy, Support, and Training (FAST) Program, Expanded School Mental Health (ESMH), Adolescent Suicide Prevention and Early Intervention (ASPEN) and Transitioning Youth.

The *Division of Alcoholism and Drug Abuse* is the Single State Authority (SSA) responsible for prevention, control, treatment, rehabilitation, educational research and planning for substance abuse related services. The Division's priorities during the past several years include preventing the onset or initiation of substance use by young people, preventing or reducing the consequences of underage and adult problem drinking, reducing prescription drug misuse and abuse in the general population, reducing the number of drug-exposed pregnancies, reducing the number of drug-related deaths, reducing the number of repeat Driving Under the Influence (DUI) offenses, increasing the number of substance treatment services to meet the need of communities, and increasing the number of recovering individuals living and working in a safe and supportive environment.

The *Division of Intellectual and Developmental Disabilities* provides leadership, facilitation, technical assistance and funding to support children and adults who have intellectual/developmental disabilities. The Division's priorities include increasing self-advocate/family/provider awareness of and access to community services and supports, and developing services and supports for individuals with complex support needs and youth transitioning to adulthood.

The *Office of Consumer Affairs and Community Outreach* (CACO) provides a collaborative support role to the above referenced clinical sections through ongoing collaboration with advocacy groups and local agencies on mental health, substance abuse and intellectual and

developmental disability policy issues on designing and implementing the operation of the statewide behavioral health promotion and prevention network. The networks include stakeholder groups, including consumers, family members, advocates, providers, the general public, and service organizations, all of which help increase awareness and provide training opportunities on best practices and health promotion/risk reductions models. Priorities during the past several years have included coordinating Bureau training events including recovery coaching and Mental Health First Aid, expanding peer supports, behavioral health disaster coordination, planning and response, anti-stigma and health promotion activities, developing a certification process for Community and Peer Support Specialists and Recovery Coaches, tracking legislation and establishing a centralized intake process for issues arising from the general public and other stakeholders. As West Virginia's new statewide call line becomes operational September 2015, CACO will actively partner with First Choice, Inc. in order to support continuous quality improvement and ensure that all identified barriers are quickly evaluated and resolved with provider continuums statewide.

SSA/SMHA Roles and Responsibilities

- Comprehensive statewide planning for the provision of an appropriate array of community-based behavioral health services and continuum of care
- Integration and coordination of the public behavioral health system
- State-level program funding decisions based on behavioral health indicators and program evaluation data
- Prioritization and approval of all expenditures of funds received and administered by the BBHHF, including the establishment of rates, reimbursement methodologies and fees
- Oversee implementation of the agreed upon Hartley Consent Decree order related to community support activities, including but not limited to, expansion of Care Coordination services, expansion of group homes and residential services, and the development of additional day supports
- Partner with DHHR Bureaus for Children and Families, Medical Services, and Public Health, on community issues, including licensure and regulation of behavioral health professionals, programs and facilities
- Promotion of activities in research and education to improve the quality of behavioral health services; recruitment and retention of behavioral health professionals; and, access to behavioral health programs and services
- Implementation of the responsibilities related to behavioral health required by state law, as referenced in West Virginia Code, Chapter 27, Article 1A et seq. and all applicable legislative rules

BEHAVIORAL HEALTH PROVIDER SYSTEM

West Virginia's publicly-funded community based behavioral health system is anchored by thirteen (13) Comprehensive Behavioral Health Centers (CBHC's), operating full service and/or satellite offices in each of the counties located in the center's catchment area. Public behavioral health services provided by a CBHC are for all populations and all ages at risk for, or have a diagnosis of, mental illness, substance abuse, intellectual/developmental disability, or a co-occurring/co-existing disorder. The Comprehensive Behavioral Health Centers are expected to assure the following "essential services" are available and accessible in each county: Assessment, Outpatient services (with referral for Intensive Outpatient Services (IS) as may be assessed/needed), Information and Referral capacity and Medication Management.

The majority of "essential services" are billable through third party payers, but additional funding may be needed to assure availability of these services at the county level. Continuum Enhancement Funds are provided by the BBHHF to meet this need. Charity Care State general revenue funds are also provided to insure that no one is turned away for inability to pay. The BBHHF provided $6,626,813.17 to pay for uncompensated care in FY 2015. The funding supports the development and provision of services and activities that are not otherwise billable through other funding streams or that exceed any approved service limits or caps. These funds may not be used for costs covered by an organization's administrative or indirect cost plan**.**

There are approximately 80 other partnership grants awarded to six regional prevention agencies, smaller nonprofit organizations, schools and other state agencies to decrease substance use and promote mental health and wellness, through the building of effective coalitions and implementing evidence based services in 55 Counties. Current data driven prevention priorities include: Stigma Reduction, Prescription Drug Abuse, Under-age Drinking, Physician Engagement, Drug Exposed Pregnancy, Suicide, and Bullying.

CHILDREN, YOUTH AND YOUNG ADULT BEHAVIORAL HEALTH SERVICE SYSTEM IMPROVEMENTS

The BBHHF is partnering with the state agencies responsible for public education, juvenile corrections and child welfare to develop consistent standards and outcomes for the various federal and state grants that support school-based services designed to prevent students from becoming involved with or deepening their involvement with the juvenile justice system.

Additional partners include West Virginia's early childhood system to coordinate efforts to address emotional, social and behavioral well-being of our youngest citizens and their families. Practice standards and outcomes are being established through the WV Infant Mental Health Association that can be tracked and monitored across multiple systems (mental health,

substance abuse, child welfare, health, early care & education) that serve very young children and their families.

West Virginia is currently conducting a demonstration project called Safe at Home West Virginia, which aims to provide wrap-around behavioral health and social services to 12-17 year olds with specific behavioral health needs who are currently in congregate care or at risk of entering congregate care. The Department of Health and Human Resources will also be providing pilot programs over the next 2 years to complement the Safe at Home Initiative through an increase of school based behavioral health services and implementation of the START program, an intensive intervention model for substance abusing parents and families involved with the child welfare system that integrates addiction and recovery services, family preservation, community partnerships and best practices in child welfare and substance use disorder treatment. The program addresses system issues that result in barriers to families being able to access services in a timely manner.

West Virginia's youth service system now includes behavioral health service centers located in each of the six regions of the state serving as centers of excellence for the implementation of the cross-system collaborative approach. The realignment and infrastructure support for Regional Youth Service Centers in conjunction with additional long standing youth initiatives funded by the Bureau for Behavioral Health and Health Facilities including Partnerships for Success, Suicide Intervention, Children's Clinical Liaisons, WV System of Care, Expanded School Based Mental Health, Family Advocacy, Support and Training, Children's Homeless Outreach, and Transitioning Youth to Independence demonstrate the behavioral health experience and capability to effectively promote system-level change, perform intensive community work and integrate behavioral health service state wide.

ADDRESSING CULTURAL COMPETENCE

West Virginia requires training for all providers to be able to implement culturally competent evidence-based programming statewide with a special emphasis on priority populations that include: pregnant women, service members, veterans and their families, transitioning-aged youth, IV Drug Users, individuals experiencing homelessness and individuals identifying as lesbian, gay, bi-sexual and transgendered. Courses in health disparities and special population engagement are included during the statewide integrated behavioral health conference and regional training and technical assistance efforts. Examples of specific effort to reach priority populations are listed below.

INCIDENCE AND PREVALENCE IN BEHAVIORAL HEALTH INDICATORS

The Center for Integrated Behavioral Health Policy states that substance use problems are among the most common and costly health conditions affecting Americans with over 21 million

adults meeting the diagnostic criteria for alcohol abuse or dependence, illicit drug abuse or dependence, or prescription pain medication abuse or dependence. The State of West Virginia (WV) is no different with regard to costly physical and behavioral health conditions but for the third year in a row, West Virginia has decreased the overall misuse of prescription drugs and worked hard to improve community norms that balance hope with concern for achieving a substance-free West Virginia. Funding allocated by Governor Tomblin and appropriated by the WV Legislature has been awarded to support the development of high priority services in areas of the state where such services were determined to be limited in availability or non-existent.

WV IMPROVED STATISTICS (SOURCE: NATIONAL SURVEY ON DRUG USE AND HEALTH)

DESCRIPTION	2009-2010	2012-2013
Past month illicit drug use (12-17 year olds)*	9.36%	6.95%
Past month illicit drug use (18-25 year olds)*	22.12%	17.34%
Past year nonmedical pain reliever use (12-17 year olds)	7.25%	4.16%
Past year nonmedical pain reliever use (18-25 year olds)	14.39%	8.65%
Past month marijuana use (12-17 year olds)	6.1%	5.2%
Past month marijuana use (18-25 year olds)	18.9%	14.9%
Past month marijuana use (26+)	4.0%	3.6%

DESCRIPTION	2011	2013
WV drug overdose deaths	656	550
WV calls to Poison Control Center re: bath salts	253	15

DESCRIPTION	2009	2013
Students grades 9-12 ever using heroin	4.4%	2.2%
Students grades 9-12 ever using meth	6.5%	3.6%

HIGHLIGHTS

- Past month marijuana use in WV decreased significantly between 2009-2010 and 2012-2013 in both 12-17 year olds and 18-25 year olds.
- Past month use of Illicit drugs other than marijuana in WV also decreased between 2009-2010 and 2012-2013 in both 12-17 year olds and 18-25 year olds.
- Students in grades 9-12 who reported ever using heroin dropped significantly between 2009 and 2013.
- Students in grades 9-12 who reported ever using meth dropped significantly between 2009 and 2013.
- In 2013, WV Poison Control reported only 15 calls related to Bath Salts, compared to 253 in 2011.
- Decrease in overdose deaths from oxycodone and hydrocodone
- Decrease in overall misuse in prescription drugs

Results from the recently released 2014 Monitoring the Future (MTF) Survey of drug use among adolescents provide hope for families across the nation. No major drug use indicators increased significantly between last year and this year; use of alcohol, cigarettes, and illicit and prescription drugs either held at the same level, or in many cases, declined among American teens and those findings mirror those in West Virginia. While these successes are to be celebrated, there is much work to do at State and National levels and will be discussed further with regard to needs and gaps. The continued abuse of other substances including alcohol, and the comeback use of heroin creates societal problems with an increasing cost burden to the State.

PREVENTION AND PROMOTION SERVICES

The Bureau for Behavioral Health and Health Facilities allocates funding to six regional prevention lead organizations that provide technical support to local Prevention Coalitions in all 55 counties in West Virginia (WV). All prevention grantees implement the following strategies: information dissemination, prevention education, community mobilization, environmental strategies, alternatives for youth and problem identification and referral. All counties are required to complete the strategic prevention framework planning model to identify needs and match evidence based programs and practices. The following are the most frequent programs implemented statewide: Keep a Clear Mind, Second Step, All Stars, Too Good for Drugs, Healthy Alternatives for Little Ones (HALO), Incredible Years, and Too Good for Violence for Elementary age students. Keep a Clear Mind, All Stars, Creating Lasting Family Connections (CFLC), Too Good for Drugs, Not On Tobacco, Second Step, Alcohol Literacy Challenge, Lions Quest skills for adolescents, AlcoholEDU for High School, Life Skills LST, Drugs: True Stories and Alcohol True Stories Hosted by Matt Damon, for Middle and High School age youth, Alcohol literacy Challenge, Celebrating Families, Healthy Workplace for College aged youth and adults.

As part of on-going prevention efforts, and to maintain block grant funding, the Bureau is responsible for the coordination and implementation of Synar inspections in accordance with guidelines set forth by the Center for Substance Abuse Prevention and the U.S. Food and Drug Administration. West Virginia continues to be in compliance in limiting retail sales of tobacco to minor youth. 87.8% of retailers complied with the law barring tobacco sales to anyone under the age of 18 which was a positive increase of over 2% from last year. The inspections are conducted in cooperation with the West Virginia State Police and community partners.

Over the past year, substance abuse coalitions have provided in-depth evidence-based education programs to nearly 10,000 youth. More than 40,000 youth have attended school assemblies and presentations educating them about substance abuse. Aside from youth education, proven community trainings have been attended by nearly 14,000 adults. Various media campaigns – educating communities about substance abuse, offering resources for help,

and encouraging parents to talk to their kids about drugs – have reached nearly 1 million West Virginians through newspaper, radio, TV, print, and digital promotions. Moreover, coalitions have been able to implement local policies to prevent substance abuse, such as passing local ordinances banning the sale of designer drugs, and providing permanent depositories to safely dispose of prescription drugs. Youth-led efforts were supported by partnering with the WV Department of Highway Safety to provide the 2014 SADD (Students Against Destructive Decisions) Conference for 150 youth and 50 adult advisors to promote positive mental health, leadership development and good decision-making.

Youth-led prevention is essential in peer programming in West Virginia. There are currently 167 Students Against Destructive (SADD) chapters. West Virginia also has other youth groups including the Harrison County Dream Team which is made up of local high school students who are committed to realizing their personal goals and dreams while not allowing alcohol or other drugs to derail them in their pursuits. The Team uses the Strategic Prevention Framework (SPF) to identify needs and develop problems statements to effectively advocate for alcohol and drug free community events. The Positive Community Norms (PCN) model works to change community beliefs regarding parental attitudes around providing alcohol to youth at home to keep them safe and the need for alcohol or other drugs to have fun. Two counties have youth coalitions and West Virginia has nine RAZE clubs, which are student run groups that focus on dispelling the myths of Big Tobacco in West Virginia and two Drug Free Clubs of America, which provide support and education to students to develop refusal skills and support for a drug free lifestyle. Ten of WV's counties host Teen Summits and Teen Institutes. Cabell County, one of our most populous counties in the State, has Youth Prevention Teams in all middle and high schools in the County.

Every county in West Virginia participates in Drug Take Back events, Merchant Education, Synar Inspections and Synar Checks for Tobacco, Alcohol Compliance Inspections, Sobriety Checkpoints, Employee Wellness Fairs and Policy Change advocacy. Additionally West Virginia has a Partnership for Success (PFS) grant which focuses on the reduction of underage drinking and non-medical use of prescription opiates in 12 high need counties in the State. A component of the grant focuses on community norms change, by identifying and changing pervasive attitudes and beliefs that contribute to the targeted population problem, then developing long term core belief changes and developing values that sustain healthy attitudes and behaviors.

The Bureau for Behavioral Health and Health facilities partners with the Bureau of Public Health and the WV Department of Education to provide funding support to Regional Wellness Specialist that are housed within each RESA area of the State. This coordinated school health initiative brings together schools and community prevention specialist from health and behavioral health to plan and implemented best practices and to avoid duplication of effort.

These individuals are trained in suicide prevention, substance abuse prevention and adolescent health and serve as liaisons with schools and communities.

EARLY INTERVENTION, TREATMENT AND RECOVERY

In addition to providing prevention services, the SAPT Block Grant is a major source of funding, allocating $6.5 million for substance abuse early intervention, treatment and recovery services in West Virginia. The Bureau continues to provide funding to support West Virginia Juvenile Drug Courts. Block grant funding is also utilized to purchase evidence-based Driving Under the Influence Program curriculum to promote best practice and consistency statewide. BBHHF provides funding support to a continuum of treatment options, including outpatient and intensive services, and short and long term residential treatment that are not otherwise covered by Medicaid, Medicare, or private insurance. Block grant funds provide for community-based recovery support services that included the expansion of best practice in peer supports having trained over 200 recovery coaches statewide in every region with 29 trained as trainers and expanded recovery residences that provide focused short and long-term housing access for people who need safe and supportive housing to live drug and/or alcohol free. MTM has been awarded a contract to be the state of West Virginia's non-emergency medical transportation (NEMT) manager. The organization provides rides free of charge for eligible Medicaid Members throughout the state for covered medical services. The program was put in place to alleviate transportation barriers to treatment in a rural State.

Thirteen Comprehensive Community Behavioral Health Centers are required to offer a full continuum of publically provided Behavioral Health Services. Out-Patient Services include: Assessments, Individual, Group and Family Therapy and Medication Management. Residential Treatment Facilities are limited and prioritized for intravenous (IV) drug users, women who are pregnant, transitioning aged youth, and individuals being transitioned from a higher level of care. These facilities provide clinically managed, high intensity services that feature a planned regimen of care in a safe, structured and stable environment. Residential programming is gender specific, trauma informed and in coordination with day habilitation, rehabilitation and peer supports.

TREATMENT AND RECOVERY SERVICES/CAPACITY CHANGE

DESCRIPTION	2012	CURRENT
Regional Youth Service Centers	0	6 Locations
Change in number of Detox Stabilization	10 locations, 104 beds	13 locations, 130 beds
Change in number of Treatment and Recovery Residences by level	31 locations, 409 beds (no levels)	40 locations, 759 beds Residential Treatment Facility

		8 Locations, 102 Beds Treatment Provider Recovery Facility (Level 4): 13 locations, 195 beds Peer-Operated Recovery Facility (Level 3): 4 locations, 280 beds Peer-Operated Recovery Home (Level 2): 15 locations, 182 beds
Telehealth Medicaid Reimbursement Capacity	Limited Medical Services only	All Clinic and Rehab BH Codes with Telehealth Options

With regard to *Medication Assisted Treatment*, there are currently 187 physicians who are waivered to prescribe buprenorphine. WV Medicaid provides coverage for buprenorphine, mono-buprenorphine and vivitrol. There are currently 165 physicians that are licensed under Medicaid to provide these services. The Bureau for Behavioral Health and Health Facilities has worked with the Bureau of Medical Services (Medicaid) and the Office of Health Facility Licensure and Certification to develop a Opioid Treatment Center oversight committee to review: (1) clinic policies/procedures; (2) the implementation of the revised quarterly reports for the Health and Human Services Legislative Committee; (3) licensure reports; and (4) exception requests for take home doses. The Committee also developed a waiver process for staff with felony convictions. The administrative rules governing Opioid Treatment Centers (OTPs) was revised in 2010 based on recommendations from the Bureau for Behavioral Health and Health Facilities. The revised rules hold Opioid Treatment Centers more accountable for the services they provide, especially clinical and recovery based services. Since the implementation of rules there have been 14 pain management initial licensure surveys completed, 5 applications pending survey, 5 licensed clinics and the closure of 11 pain clinics.

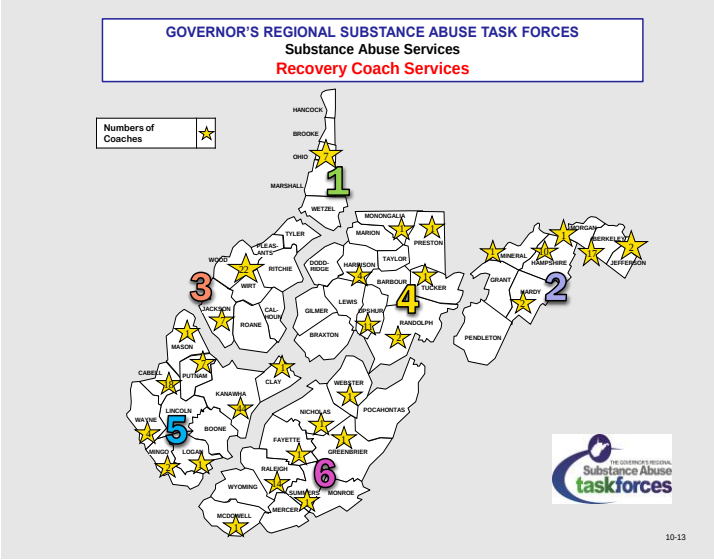
The Federal Guidelines that govern state Opioid Treatment Centers nationally do not specifically address the use of Buprenorphine in OTPs. Therefore, the Bureau of Behavioral Health and Health Facilities, via the Appointed State Opioid Treatment Authority, has been instrumental in providing clarification where needed, in the provision of these services and provides ongoing technical assistance in the expansion of these services.

Since the passage of Senate Bill 437, more physicians are accessing the Controlled Substance Monitoring Program database at patient intake, before administering, prescribing or distributing prescriptions and are receiving required continuing education on best prescribing practices. Pharmacists have also have received education on dispensing prescription

buprenorphine and electronically-submitting certain information to the Multi State Real Time Tracking System (MSRTTS) administered by the National Association of Drug Diversion Investigators (NADDI).

Peer and Recovery Support

The number of Peer-Operated Recovery Homes and Facilities has increased providing safe housing for individuals, age eighteen (18) and older, who are recovering from substance use and/or co-occurring substance use and mental health disorders. These facilities assist individuals up to twelve (12) months. Residents are encouraged to participate in outpatient and intensive services provided off site so that Medicaid may pay for Medicaid reimbursable services, which will not occur at the facility. Service areas provided by the facility include: Prevention, Health Promotion and Wellness and Recovery Support Services. Key components of a Recovery Residence include but are not restricted to drug screening, house/resident meetings, mutual aid/self-help meetings, structured house/ resident rules, peer-run groups, life skill development emphasis, and clinical treatment services accessed and utilized within the community. Staff positions include but are not restricted to a Facility Manager, Certified Peer Coach(s), Case Manager(s), and other Certified Peer staff. Resident capacity is 6-8 for home settings and 60-100 beds for residential facilities. All grantees abide by National Association of Recovery Residence Standards. There were no Recovery Coaches in 2010 and currently WV has a total of 201 trained and available in all regions of the state. The WV Bureau for Behavioral Health and Health Facilities has developed a certification process for Peer Specialists who will provide peer services for addiction, mental health and developmental disabilities.



HEALTH AND BEHAVIORAL HEALTH INTEGRATION

West Virginia has taken steps to integrate behavioral health and primary care. Nineteen of the State's 34 Federally Qualified Health Centers (FQHCs) providing 108 sites now employ a behavioral health provider. These health centers offer behavioral health services coordinated with medical services. Because these healthcare teams are able to simultaneously treat healthcare and behavioral health issues earlier, better healthcare outcomes can be achieved.

Five of the State's largest CBHCs now offer coordinated primary health care services in a community mental health setting and share behavioral health staff with rural primary care centers through co-location and integration agreements.

After eighteen years as a statewide initiative, it is widely accepted that School-Based Health Centers (SBHCs) provide easily accessible and cost-effective care and they are strongly supported by students, parents, and school staff. The goal of the statewide initiative is to ensure primary and preventive care for youth, by eliminating access barriers that children and adolescents face. There are currently 110 SBHCs in 35 counties. There are 23 sponsoring agencies of SBHCs in our state. Twenty-two are Community Health Centers, and one is a Critical Access Hospital. SBHCs are health clinics that bring preventive and immediate care, as well as counseling, health education, and sometimes dental care, to children and adolescents where they spend the majority of their day – at school. Approximately one-third of the SBHCs provide behavioral health services and through continued collaborative efforts that number continues to rise every year. The BBHHF also funds 5 expanded school mental health sites serving 15 schools offering a full continuum of prevention, early intervention and behavioral health treatment.

CHANGES IN THE WORKFORCE

Behavioral health treatment services are now provided by social workers, licensed professional counselors, psychologists, psychiatrists, and certified drug and alcohol counselors throughout West Virginia. In the past year, the Bureau of Medical Services revised their regulations, allowing Licensed Independent Clinical Social Workers to provide behavioral health services without the oversight of a Physician. Also, many Master Degreed professionals, under the supervision of a licensed professional, are able to provide Medicaid billable services under the umbrella of the Comprehensive Behavioral Health Providers. Additionally, Federally Qualified Health Centers have received over 50 million dollars in grant funding in the past two years to expand their capacity to provide behavioral health services. Several of these organizations have reached out to the BBHHF for Technical Assistance. Staff has been proactive in providing training for approximately 3000 professionals since 2010 in the fundamentals of screening, intervention and referral for substance misuse. Additionally, since 2014, 1500 nurses in primary care clinics and emergency departments were trained on how to address substance misuse in these settings.

All Substance Abuse Prevention grantees and sub-grantees develop professional development plans that focus on the knowledge, skills and abilities needed for the position that are also aligned with credentialing. West Virginia encourages IC & RC certification and is in the process of developing a community based support credential for para-professionals or those entering the field. The State Prevention Coordinator, NPN, provides training and technical assistance

and works to build the capacity of the prevention network and communities. In addition to the personalized professional development plan, all grantees must participate in group learning opportunities offered during quarterly meetings and scheduled program trainings that are required through their provider contracts, including: Substance abuse Prevention Training, Prevention Ethics, Cultural Competency, Motivational Interviewing, Suicide Prevention, Trauma Informed Care, Mental Health First Aid, Strategic Prevention Framework and Positive Community Norms.

Currently, statewide West Virginia has 9 Certified Prevention Specialist, 12 grantees or sub-grantees who are eligible to take the certification test and 17 grantees or sub-grantees who still need required work and prevention related training hours. Over the past year, statewide West Virginia has had to fill 8 vacant positions, due to the addition of the PFS grant which required each Region of the state to hire an additional two sub-grantees for a total of six new positions. Two of our previous SAPT sub-grantees moved into new PFS positions. Statewide we currently have one position that is open and one which will become vacant in August.

Physician Education and Engagement

Recent discussions on the integration of behavioral health and physical health have put medical professionals in a precarious role to become gatekeepers, educators and treatment providers. As a whole, the field has not been trained nor received adequate practical experience in addiction medicine. The lack of education, experience, inability to obtain good referral resources and their general lack of wanting to confront their patients demonstrate the necessity for workforce capacity-building in the field of medicine.

Since the implementation of SB437 requiring continuing education for all licensed physicians on best practice prescribing of opiates and understanding new guidelines through the legislation, hundreds of physicians have been trained in both face to face and web-based education venues. The BBHHF provides funding for The Appalachian Addictions Conference held yearly as well as face to face hospital and community based trainings regionally to meet the needs of the physicians. A physician's guidance document was developed by the WV Physicians Health Program and West Virginia University staff to educate physicians on screening, brief intervention, and referral to treatment as well as resource locations.

ADVANCED TELEHEALTH

The State has made a significant commitment to explore, pursue, and provide the most modern, efficient, and effective service instruments and training tools available. Funding has been made available to all service providers to support infrastructure needs to improve their capability for providing electronic health records and offer telemedicine. In order to increase access in more rural parts of the state, the Bureau of Medical Services has revised it

reimbursement manual to allow telehealth services for most behavioral health services. The BBHHF has two trainers who are available to provide Technical Assistance to behavioral health organizations to help increase capacity to provide behavioral health services via telehealth. West Virginia providers currently utilize some technology based services for aftercare interventions, peer support reminders, Assertive Community Treatment team meetings, psychiatric evaluations (when testifying as expert witnesses for the purpose of commitment hearings), some assessments, and medication assisted treatment groups. The BBHHF website is currently being improved to better accommodate consumers and families, in addition to linking communities and providers with services and resources, http://www.dhhr.wv.gov/bhhf. Additional websites have been created specifically for the Governor's substance abuse initiatives in partnership with the BBHHF, http://www.wvsubstancefree.org/ and the Mental Health Planning Council http://www.wvmhpc.org/.

Beginning in September 2015, the new 24/7/365 Health Information, Referral & Outreach Call Center will be operational providing a "real time, live" data base that includes statewide, regional and local service options, including residential treatment with bed capacity updated daily. The staff will 1) Offer education on behavioral health issues and information on service options close to home, 2) Provide facilitated referrals to an appropriate level of care that is based on the individual's need, in close coordination with regional/local providers, 3) Track and follow-up with all callers within 48 hours in order to promote quality assurance and to support timely connectivity with needed resources, and 4) Monitor and track outcomes of all service engagement.

POLICIES IMPACTING CURRENT SYSTEM IMPROVEMENTS

While programs, practices and funding are essential to service provision, policies are essential in building the infrastructure to be able to execute a sustainable framework to implement change. During the past three years significant legislation and policy decisions have influenced behavioral health in West Virginia. The Governor and lawmakers have been equally affected by the behavioral health challenges that the State has faced as well as community providers and local citizens. Any changes in prevalence, program services or system improvements would not have been possible had it not been for non-partisan support and community advocacy.

SENATE BILL 437 (2012)

- Required physician prescriber education
- Supported improvements to the Prescription Drug Monitoring Program system and reporting guidelines
- Increased coordination and oversight
- Prompted further regulation of opioid treatment programs and pain clinics

- Provided $7.5 million in State revenue for additional treatment based on regionally identified need

MEDICAID EXPANSION (2013)

- Provided insurance coverage for a large number of individuals with substance abuse and behavioral health needs

SENATE BILL 371 (2013)

- In May 2013, Governor Tomblin signed into law the WV Justice Reinvestment Act to improve the effectiveness of West Virginia's criminal justice system
- Implemented new policies to reduce the number of repeat offenders by supporting workforce training programs and ensuring access to community-based substance abuse treatment
- Since the Justice Reinvestment Initiative was signed into law, WV has reduced overcrowding in regional jail facilities by nearly 50 percent, and has reduced the overall number of corrections inmates – for the first time in 16 years – by 5 percent

SENATE BILL 252 (2014)

- The bill allows certain expelled students to return to school through Juvenile Drug Court adding an additional factor allowing School Superintendents to reduce a mandatory twelve-month expulsion for youth in possession or sale of a controlled substance on premises of educational facility via successful completion or making satisfactory progress toward successful completion of Juvenile Drug Court
- The early return to school must be approved by the Juvenile Drug Court treatment team, the court, the Student Assistance Team of the school from which the student was expelled, and, ultimately, the superintendent, who shall make the final determination

SENATE BILL 393 (2015)

- Senate Bill 393, relating generally to juvenile justice reform; a $4.5 million initiative that: places truancy diversion specialists in all 55 counties to provide early intervention services to those children who need them most
- Introduced a two-step diversion process that expands community-based alternatives prior to the filing of a juvenile petition for a status offense or a misdemeanor
- Expands youth reporting centers across the state to provide programs to children at home instead of through out-of-home placements

- Introduced evidence-based services and pilot programs to support restorative justice programs, substance abuse recovery services, mental health programs and family therapies

SENATE BILL 335 (2015)

- Allows emergency responders, medical personnel, family and friends to possess and administer a drug called Naloxone, which reverses the effects of an opioid overdose

HOUSE BILL 4208 (2015)

- Added a large number of drugs and substances to the Standards and Schedule list in Schedule I, including synthetic hallucinogens

HOUSE BILL 2535 (2015) JAMIE'S LAW

- The bill aims to increase suicide prevention awareness by requiring middle and high schools to post information about the warning signs of suicide and how students can get help
- Requires training for teachers and other school personnel to help them better recognize a student who needs help
- At the college level, officials are to advise students where they can get help either on or off campus and publish a policy on the school's website

SENATE BILL 523 (2015)

- relating to obtaining emergency medical assistance for persons who may be experiencing alcohol or drug overdose
- provides immunity from prosecution in limited circumstances for persons who call for emergency medical assistance for person who reasonably appears to be experiencing drug or alcohol overdose
- states seeking emergency medical assistance may be raised as mitigating factor at sentencing in certain criminal proceedings and other clemency options for the court to consider for persons who experienced drug or alcohol overdose for whom emergency medical assistance was sought
- allows persons to plead guilty to certain exempted criminal offenses if desired; and providing law-enforcement personnel limited civil immunity in arresting or issuing citations, except in cases of willful, wanton and reckless misconduct

HOUSE BILL 2527 (2015)

- relating to the welfare of children; establishing the Task Force on Prevention of Sexual Abuse of Children; authorizing section to be called “Erin Merryn’s Law” relating to legislative findings and declaration of intent for goals for foster children
- requiring the Department of Health and Human Resources to propose legislative rules; providing that no new cause of action against the state is created; providing that no expenditure of funds is required; and providing for notifying former foster parents of child’s availability for placement

HOUSE BILL 2550 (2015)

- relating to truancy intervention; defining excused and unexcused absences; providing that notice of a student’s three unexcused absences be given to parent, guardian or custodian
- providing that a parent, guardian or custodian have a mandatory conference with the principal or other designated representative of the school when the student has five unexcused absences; and increasing number of unexcused absences by a student before a complaint must be made against the parent, guardian or custodian of the student

HOUSE BILL 2880 (2015)

- relating to creating an addiction treatment pilot program
- requiring the Secretary of the Department of Health and Human Resources to create an addiction treatment pilot program working with the Supreme Court of Appeals and the Division of Corrections to participate in the medication assisted treatment pilot program

HOUSE BILL 2598 (2015)

- relating to school accommodations for exceptional children; and requiring that teachers receive instruction relating to the school‘s plan of accommodations for students with disabilities

HOUSE BILL 2999 (2015)

- authorizing neonatal abstinence centers and requiring the DHHR Secretary to promulgate emergency rules to set out a licensing procedure by July 1, 2015 to set minimum standards of operation for neonatal abstinence centers
- requiring the state agency to consider neonatal abstinence care as a unique service in conducting certificate of need review and exempting neonatal abstinence centers from moratoriums on certain nursing facilities
- prohibits the Health Care Authority from ordering a moratorium on skilled nursing facilities providing services for children under one year of age suffering from Neonatal Abstinence Syndrome; and exempting such facilities from current moratoriums

PLANNING AND ALLOCATION OF FUNDS

Over the past five years WV has learned valuable lessons in re-developing a behavioral health service continuum including: 1) System-wide assessment involving multiple partners is key but it takes time and patience; 2) Establishing and continuing relationships with partners statewide is critical; 3) A top down – bottom up approach is central to success; 4) Data informed decision-making must guide process; 5) Funding is one part of success – grassroots efforts and collaborations are impactful and cost effective; 6) Strategies must be comprehensive and flexible in nature; and 7) Keep the end always in focus – people's lives depend on it.

On September 6, 2011, West Virginia Governor Earl Ray Tomblin established the Governor's Advisory Council on Substance Abuse (GACSA) through Executive Order No. 5-11. The GACSA includes Cabinet level positions in the WV DHHR, Department of Military Affairs and Public Safety, and the Department of Veterans Assistance; persons in leadership positions representing the State Police, Chiefs of Police, Sheriffs, Supreme Court, Schools, WorkForce West Virginia, the BBHHF; and experts from the fields of behavioral medicine, substance abuse prevention and treatment, the faith-based community, homelessness, domestic violence prevention, and a range of health professionals.

These critical partners are necessary to provide a sustainable infrastructure ready to implement successful initiatives statewide. The roles and responsibilities of the GACSA include: Provide guidance on implementation of the Statewide Substance Abuse Strategic Action Plan; identify planning opportunities with other interrelated systems to increase both public and private support concerning substance abuse initiatives; recommend a list of priorities for the improvement of the substance abuse continuum of care; receive input from local communities throughout West Virginia; and provide recommendations to the Governor to improve education, data needs, employment opportunities, communication, crime prevention, and other matters related to substance abuse.

In addition, Governor Tomblin established six Regional Substance Abuse Task Forces (RTF) covering West Virginia. The RTF meetings are open to the public and have involved West Virginia citizens from a multitude of areas, including local elected officials, service providers, suicide coalition members, the Behavioral Health Planning Council, and the general public. Since its issuance, the GACSA has met face to face nine times, and the RTFs in each of the six regions have held 16 rounds of meetings (96 local meetings statewide), with almost 4,000 people attending and participating. During these meetings, members identified gaps in the array of service delivery, gained information about various topics related to Prevention, Early Intervention, Treatment, and Recovery, and recommended priorities for strategies and allocation of resources. The GACSA assimilated information gathered at the local level with state and regional data to report progress and recommendations to the Governor each year.

The outcome of these activities has resulted in significant changes in legislative policy, service availability and delivery, an addition of $10 million in funding, shared resources, and collaboration. This top down, bottom up approach for policy, planning and partnerships is West Virginia's preferred model for planning and allocation of all behavioral health funds.

The State of West Virginia provides general revenue funds supporting approximately 93% of dollars spent on the public behavioral health system. The remainder is provided through the SAPT/MH Block Grant and other discretionary grant awards that currently include: FDA State Tobacco Compliance Check Inspection Program, WV SPF Partnerships for Success, Suicide Prevention/ Intervention, Youth Treatment Planning and Projects for Assistance in Transition from Homelessness (PATH) and National Child Welfare and Substance Abuse Technical Assistance. Additional discretionary grants have been awarded to State universities and community providers exceeding $10million dollars.

Allocation decisions are made by program leadership in collaboration with fiscal and administration section members by:

- Reviewing prevalence and perception data collected by WV State Epidemiological Outcomes Work Group (WVSEOW) and SAMHSA Behavioral Health Barometer
- Assessing and reviewing service gaps by region indicated by community input and reporting data
- Reviewing provider funding service utilization data trends
- Obtaining and incorporating federal funding guidance
- Researching and including best practices into funding announcements and grant agreements

Funding allocation categories include 1) Medical Services that are provided through Charity Care that are Medicaid reimbursable services provided to individuals who are not Medicaid eligible, 2) Infrastructure & System Capacity for Continuum Enhancement Funds to support the development and provision of essential services that are not billable through other funding streams or that exceed any approved service limits or caps, and 3)Targeted Community Based Services & Supports are services that support individuals to improve their own health and wellness and to live a meaningful life in a community of their choice while striving to achieve their goals and direct their future. In most cases, block grant funding is used to provide services in category 3.

Over the past two years the Bureau has been successful in its effort to further incorporate systems change through the realignment and redirection of funding to cover new reimbursable services and Medicaid expansion supported greater treatment capacity. In addition, a standardized service array with definitions has been developed to better understand service

needs at state, regional and local levels. Behavioral health codes were developed in coordination with providers to track services to evaluate utilization and to work with Medicaid to cover services. Grant agreements were revised in response to new announcements of funding and solicitation and review processes were implemented. Partnerships within State government and private organizations were developed and sustained to support a comprehensive service continuum to benefits West Virginia citizens.

MEETING THE NEEDS OF PRIORITY POPULATIONS

While West Virginia has an integrated system of behavioral health services provided by comprehensive behavioral health organizations the following populations are given priority consideration and targeted programs are included to describe the emphasis of care placed on the groups identified.

Pregnant Women and Women with Dependent Children

- The Bureau for Behavioral Health and Health Facilities has expanded the number of recovery residences for women to include 90 beds, with additional programs being added daily to provide a safe, supportive and sober environment.
- The State also has four specific facilities for pregnant women and their children to engage in family treatment during their residential stay with additional recovery residences providing a safe and supportive environment for more than 80 women.
- WV was awarded special support from the National Center for Child Welfare and Substance Abuse providing 18 months of federal technical assistance and support to improve the safety, health, permanency and well-being of substance-exposed infants and the recovery of pregnant and parenting women and their families in West Virginia, building on the existing statewide planning initiative on substance exposed pregnancies. The State is looking for two specific products to be developed and disseminated as a result of this support, 1) State guidance document regarding protocols and policies related to substance exposed pregnancies/children, and 2) Guidance document on best practices for working with pregnant women and their children within the recovery community.

Individuals Injecting Drugs (Tuberculosis, HIV, Hepatitis)

- While WV has never received the designation of being an “HIV State”, the State has always required that priority be given to this population for treatment admission. Due to increased Heroin and Hepatitis rates, the State has partnered with the Bureau for Public Health and local communities to provide funding and technical support for needle exchange programs and enhanced outreach and education programs in high need targeted areas.

- All BHHF grantees are required to screen for HIV, Hepatitis and Tuberculosis and fiscal codes have been added to support health screens if not covered by other payers.

Children with SED

Historically, parents searching for services for their children with serious emotional disturbances have had two options. They can retain custody of their child and receive services through traditional outpatient therapy, psychiatric residential treatment facilities, or inpatient psychiatric hospitals, all of which are funded through third party insurance, including Medicaid. (In FY2013, 502 youth were placed in out of state PRTFs; 347 of them were in parental custody). Children who have been temporarily or permanently removed from parental custody due to abuse, neglect or delinquency have access to community based services, foster family-based care, emergency shelter care, residential group care, or transitional living services. Consequently, many children identified with serious emotional disturbances/disorders are served by other entities of state government: the Bureau for Children and Families (responsible for children at risk for maltreatment); the Bureau for Medical Services (payer for outpatient and psychiatric residential treatment services); and the Division for Juvenile Services (serving children adjudicated for status and criminal offenses).

The child-serving system, in general, has drifted toward a more residential bias over time. (see section 17) Recognizing that, the BBHHF began partnering with those systems to better understand the needs of families and children they serve, and to determine the best role for the state behavioral health entity. Results of those partnerships include development and expansion of school-based mental health services, significant growth in suicide prevention/intervention services, outreach and support for children experiencing homelessness, and transitional living services for youth aging out and in need of services from the adult behavioral health system.

However, one of the most significant roles the Bureau plays is providing clinical expertise about SED via training, technical assistance, case management, and other forms of engagement and coordination at both the individual and system levels. Consistent with our system of care values, BBHHF specifically uses block grant funding for:

- "core training" across systems in Person-Centered Planning, Trauma-informed Care and Cultural Competency;
- Specialized training to address the needs of youth with significant trauma due to sexual abuse, violence in the home, experiences resulting from identifying as LGBTQ;
- Family and Youth engagement initiatives to help ensure they have a meaningful voice in their own service planning and delivery, as well as a voice in systems development;

- Regional Interagency Case Consultation teams that review and make recommendations for youth with complex support needs at risk of out of state placement;

Through a public/private partnership, West Virginia's child-serving systems continue to work to address the issues that will reduce congregate care and develop a comprehensive community-based array of services throughout West Virginia.

Adults with SMI

Adults with SMI have access to outpatient services, intensive outpatient services, crisis stabilization, Assertive Community Treatment, group homes, permanent supportive housing, day support programs, drop-in centers, and peer coaches provided by 13 comprehensive behavioral health centers that is required to offer services to citizens in all 55 counties. BBHHF has ongoing meetings with community providers, the Bureau for Medical Services (Medicaid), the Bureau for Child and Family, the WV Behavioral Health Planning Council and various other adult serving agencies to review and evaluate existing services and alleviate gaps in services.

Older Adults with SMI

Older adults with serious mental illness have access to all services available to adults with serious mental illness. West Virginia's Bureau for Senior Services is responsible for services including transportation, meals, exercise classes, and in-home services. BBHHF staff consistently attends meetings with the Bureau for Senior Services to assist with analysis of need and consultation with development of services. The BBHHF funds mental health services for older adults who are unable to travel to their local behavioral health center that require in-home services.

TARGETED OUT REACH AND COMMUNITY BASED SERVICES FOR PRIORITY POPULATIONS

- BBHHF has applied for and received annual Projects for Assistance in Transition from Homelessness (PATH) grants to aid individuals who are homeless and mentally ill. All 6 regions of the state have a PATH provider in addition to the WV Coalition to End Homelessness who oversees the Balance of State. Outreach efforts have been the focus in all trainings with PATH providers and are specifically mentioned in all grant agreements
- BBHHF received technical assistance regarding rural homeless outreach and plans to continue this as an ongoing request for assistance. In order to prevent and end homelessness in West Virginia, Governor Earl Ray Tomblin revitalized the West Virginia Interagency Council on Homelessness through Executive Order No. 9-13. The Council is charged with the development and implementation of a plan to prevent and end

homelessness in the State of West Virginia. This council is housed within and chaired by the BBHHF

- BBHHF funds each of the 13 regional CBHCs and a number of independent community agencies to provide community based supports to people with mental health issues, addictions and non-waiver funded people intellectual developmental disabilities that are at risk for hospitalization. $10 million in BBHHF Charity Care funds are available to support people who are uninsured and/or underinsured seeking Medicaid eligible treatment services from the 13 regional CBHCs
- Recovery Point of Huntington (formerly the Healing Place of Huntington) provides a long-term residential program of recovery from alcohol and drug addiction. The recovery center offers 100 beds to men (often experiencing homelessness) needing recovery services. Additional recovery residences are being developed across the State.
- Money Follows the Person – Take Me Home WV - In addition to expanding transition navigator services to all 55 counties in the state, Take Me Home leverages available Federal grant dollars to enhance services and supports for those who wish to leave institutions and receive services in a community or home-based setting. TMH WV employs a full-time Housing Coordinator to assist with identifying both short and long-term solutions to lack of appropriate housing
- The West Virginia Department of Education McKinney-Vento Act formula is funding 18 grants for three years. The Office for Coordination of Education of Homeless Children and Youths in each state, which gathers comprehensive information about homeless children and youth and the impediments to their regular attendance at school. These grants also help state educational agencies ensure that homeless children, including preschoolers and youths, have equal access to free and appropriate public education. States must review and revise laws and practices that impede such equal access. States are required to have an approved plan for addressing problems associated with the enrollment, attendance and success of homeless children in school. States also must make competitive sub-grants to local educational agencies to facilitate the enrollment, attendance and success in school of homeless children and youths. This includes addressing problems due to transportation needs, immunization and residency requirements, lack of birth certificates and school records, and guardianship issues
- The Huntington West Virginia Area Habitat for Humanity veterans housing initiative which is designed to help veterans own their own homes
- The West Virginia Department of Veteran's Assistance's transitional unit established at the state's Veterans Home
- Prevent Suicide WV offers suicide prevention services across the life span, establishing a coordinated State and regional learning, referral, and intervention approach with

education, juvenile justice, homelessness programs, corrections, senior services, veterans' services, behavioral health and other healthcare public/private partners

- The Children's Homeless Outreach Program provides a secure healthy environment, case management, life skills education, brief counseling, referrals and linkage to community services and supports for children and their families who are experiencing homelessness and are residing in one of the homeless shelters
- Permanent Supportive Housing provides support services for up to 16 hours per day to individuals who have a diagnosis of serious mental illness or co-occurring with a substance use diagnosis, who have been identified as high risk or who are committed to and/or discharged from an in-patient state hospital/diversion facility. These services offer support in their own housing and in the community as determined by individual needs. Individuals who do not currently have their own residence will be assisted in obtaining housing. The goal is for individuals to live fully in the community of their choice while having access to staff to support them throughout the day and evening
- Day Program Services are provided to individuals with a diagnosis of mental illness, substance abuse, intellectual/ developmental disability, or co-occurring disorders in a community based setting and may vary in services based on the population and disorder. Services may be located within a residential or non-residential setting and are to be provided 5 days/week, 3 hours daily. The goal is to optimize self-help and adaptive skills that are person-centered and guided by the consumer's needs, wishes, desires and goals. These services enhance existing relationships, open doors to information, diminish feelings of isolation and foster community engagement
- Drop-In Centers serve the needs of individuals with a mental health and/or co-occurring substance use disorder outside of the traditional mental health system. The Centers provide a safe, inviting, nonjudgmental environment for individuals to socialize, communicate and participate in activities that support recovery. They also allow individuals the opportunity to learn to live in the community and to take control of their lives. Individuals are able to interact with others who have shared similar experiences. They are designed to be consumer-driven in governance
- Group Homes provide support twenty-four hours a day seven days a week (24/7) to individuals with a diagnosis of severe persistent mental illness and/or a co-existing diagnosis of mental health and substance use disorders. This program promotes the recovery of the individuals residing in the home. The programs identify the strengths, needs, aptitudes and preferences of the individuals being served, then design skill development activities, and develop the supports that the residents need to be successful in their environment of choice
- The Transitional Living Program (TLP) provides safe housing for individuals, age eighteen (18) and older who are in recovery from co-occurring mental health and substance use

disorders. The service follows and/or is concurrent with behavioral health treatment and is intended to assist those individuals for a period of months or until it is determined that an individual is able to safely transition into a more integrated environment

- Recovery Coaching and Peer Support Services are provided by individuals who have "lived experience" and are a valuable resource to individuals seeking treatment and in recovery. Peer support services are designed to help individuals remove personal and environmental obstacles to his or her recovery, link the newly recovering person to the recovering community, and serves as a navigator and mentor in the management of personal and family recovery
- BBHHF provides informational "tool kits" and training about services available for individuals with an intellectual or developmental disability to increase linkage of individuals experiencing homelessness

DISASTER PREPAREDNESS FOR SPECIAL POPULATIONS

The BBHHF employs a fulltime Disaster Coordinator and a part-time Disaster Planner who collaborates with first responders, hospitals, local health departments, social services, homeland security and emergency management agencies, faith based community, and voluntary organizations to develop disaster response plans, continuance of operations plans and to conduct table top and other exercises across the State. The BBHHF uses $70,602 in Health Resources and Services Administration (HRSA) funds from the West Virginia Bureau for Public Health (BPH) to support regional preparation, planning, mitigation, response and long term recovery activities across the state, including for activities of the Voluntary Agencies Active in Disasters (VOAD) and integration of the Disaster Behavioral Health and the Disaster Spiritual Care Programs in order to meet behavioral, emotional, and spiritual care needs of the affected individuals, responders and recovery workers, and the communities as a whole.

The BBHHF is an active member of the BPH's Special Populations workgroup, which has adopted Kentucky's approach to this issue by supporting local relationships between people with disabilities, first responders, health care providers and hospitals. This workgroup assembles resources to help people with disabilities plan for and survive local and regional disasters. Finally, the BBHHF is working with various groups, such as the BPH, the State Red Cross chapter, West Virginia Division of Homeland Security and Emergency Management, and VOAD, to develop processes, policies, plans and annexes for inclusion of those with access and functional needs in the State's various Emergency Operations Plans and for the activities listed in The National Response Framework (NRF) under Emergency Support Function #6, including mass care and sheltering, housing and human resources as well as the transition into the Health and Human Resources Recovery Support Function under the National Recovery Support Framework in order to promote self-sufficiency and continuity of the health and well-being of affected individuals, particularly the needs of children, seniors, people living with disabilities whose members may have additional functional needs, people from diverse origins, displaced, and underserved populations.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, and substance abuse treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase behavioral health services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

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[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

BG Step 2: Identify the Unmet Service Needs and Critical Gaps within the Current System

MAKING DATA INFORMED DECISIONS

The Bureau for Behavior Health and Health Facilities continues to be the designated host agency for the State Epidemiological Outcomes Workgroup (SEOW) project. The West Virginia SEOW was assembled to lead the statewide systematic process to gather, review, analyze, translate and disseminate information about substance use and abuse and mental health in West Virginia. State, Regional and County profiles are compiled for web-based dissemination and updated yearly. Data reported in the West Virginia Behavioral Health Epidemiological Profile (State-level) is compiled by partnering WVSEOW agencies, including: CAMC's Health Education & Research Institute, First Choice Services, Inc., the Governor's Highway Safety Program, West Virginia Bureau for Children and Families, West Virginia Bureau for Medical Services, West Virginia Bureau for Public Health-Office of Epidemiology and Prevention Services, West Virginia Bureau for Public Health-Health Statistics Center, West Virginia Bureau for Public Health-Office of Maternal, Child and Family Health, Division of Research, Evaluation and Planning, West Virginia Coalition Against Domestic Violence, West Virginia Coalition to End Homelessness, West Virginia Department of Education Office of Healthy Schools, West Virginia Department of Education Office of Research, West Virginia Division of Corrections, West Virginia Division of Justice and Community Services-Office of Research and Strategic Planning and Justice Center for Evidence Based Practice, West Virginia Statistical Analysis Center, West Virginia Health Care Authority, West Virginia Higher Education Policy Commission, West Virginia National Guard Prevention, Treatment and Outreach, West Virginia Poison Center Robert C. Byrd Health Sciences Center, Charleston Division, West Virginia State Police, the West Virginia Supreme Court of Appeals, West Virginia Rural Health Association, West Virginia Bureau of Prisons, WV Controlled Substances Monitoring Program-WV Board of Pharmacy and the WV Division of Motor Vehicles. The BBHHF has expanded research and planning efforts to further enhance the ability and capacity to garner, evaluate and expand behavioral health profiles system wide.

The West Virginia Poison Control Center leads the Early Warning Work Group that identifies trends in substance abuse and provides alerts to educators, behavioral health providers and law enforcement. Regional Data and Planning Teams (DPT's) support the collection and translation of data at the community level and are facilitated by regional prevention grantees, with a required membership that includes: Law Enforcement, Education, Health, Mental Health and Youth. To further validate community based discussions on "new drugs and methods of use" a new system was put into place with all prevention grantees. During each educational presentation on substance use a section was developed to facilitate participant response and all

information is gathered and forwarded to the State Prevention Coordinator and WVSEOW Epidemiologist for review and verification in coordination with the Early Warning Work Group.

The WVSEOW and the DHHR State and Provider (Quick Fix) Team has determined that while some data gaps exist with regard to indicators to effectively measure quality and service utilization reporting, there are also duplications of reporting and that is currently being studied for system ease and improvement. More often the issue of non-sharing of data and/or lack of awareness of indicator data held by other agencies seem to be the greatest identified need. The WVSEOW will work in coordination with the BBHHF Leadership and Data Team and other DHHR Staff to:

- Capture data at the zip code level
- Produce and disseminate current data while still insuring that proper vetting occurs
- Work together to evaluate and report cost analysis/cost savings across systems (Inmate population, substance exposed pregnancies, peer/recovery supports and SBIRT)
- Obtain and disseminate real-time data for the early warning alerts
- Develop and disseminate “WV Responds” compilation of effort around “hot topics”
- Improve data measures for measuring consumer engagement, services and satisfaction
- Increase and sharing of reports from the PDMP and Medicaid systems
- Develop and publish quality report cards for providers

DETERMINING NEED THROUGH DATA COLLECTION AND ANALYSIS

In addition to obtaining community level data through consumer and community voice, the Bureau has determined future direction based on service gap information and other prevalence data not already included in Step 1 which focused on all of the positive results attained over the past two years. This information is collected through the WVSEOW membership and the BBHHF treatment data set.

Understanding the uniqueness of the rural Appalachian culture is fundamental to planning and implementing a successful statewide system of behavioral health care in West Virginia. According to most recent census data there is little racial and ethnic diversity in West Virginia, with 94.1% of the population identifying as white, 3.5% of the population identifying as black, 0.7% of the population identifying as Asian, and 1.7% of the population identifying as some other race. Only 1.3% of West Virginia’s population identifies as Hispanic or Latino, compared to 16.7% in the United States as a whole. Gilmer County has the most diversity, with 5.8% of its residents identifying as being of Hispanic origin and 12.7% identifying as Black. Other counties with higher rates of racial/ethnic diversity include Jefferson, Berkeley, Raleigh, Kanawha, and McDowell. West Virginia is tied with 3 other states as having the lowest percentage of adult literacy, with about 20% of the general population falling into the lowest level of literacy.

By any measure West Virginia residents are among the poorest in the country, coming in 49th, ahead only of Mississippi. As a result, the financial responsibility for health and behavioral health care, as well as associated socioeconomic supports (food, housing etc.), falls most heavily on West Virginia's State resources, which are often insufficient to meet the associated needs. Accessible transportation is especially limited in the State, with only 30 of 55 counties having public transit systems and only 33 counties with taxi services. According to the National Institutes of Health, the estimated total overall costs of substance abuse in the United States, including productivity and health- and crime-related costs, exceeds $600 billion annually.

The SAMHSA-funded 2013 West Virginia Health Barometer highlighted findings over a four-year period which determined that overall substance use in West Virginia is consistent with national trends. During the survey period, about 87,000 persons aged 12 or older were dependent on or abused alcohol and 48,000 persons aged 12 or older were dependent on or abused illicit drugs. In West Virginia, about 85,000 persons aged 21 or older reported heavy alcohol use within the month prior to being surveyed. Of these, about 1 in 10 received treatment for alcohol use within the year prior to being surveyed. Among persons in West Virginia enrolled in substance use treatment in a single-day count in 2012, 65.3% were in treatment for a drug problem only, 10.9% were in treatment for an alcohol problem only, and 23.8% were in treatment for problems with both drugs and alcohol. In a single-day count in 2012, 4,506 persons in West Virginia were receiving methadone as part of their substance use treatment, and 984 were receiving buprenorphine. Neonatal abstinence syndrome (NAS), a postnatal drug withdrawal syndrome that is primarily caused by maternal opioid use, has been on the rise nationwide as well as in West Virginia, and is characterized by an increased incidence of seizures, respiratory symptoms, feeding difficulties, and low birth weight. While illicit drug use in pregnancy is reported to range from 10 to 14% nationally, a 2009 WV study involving the anonymous collection and assay of umbilical cord segments in as many patients as delivered in the month of August 2009 found that 19%, almost one in five babies had evidence of alcohol or/and drug exposure. The Marshall University Medical Center Department of Obstetrics & Gynecology reported 28 NAS births per 1000 in their facility in 2009 and 80 per 1000 in 2012.

According to the West Virginia University Center for Excellence on Disabilities, the State has a high prevalence of disabilities among its children, with the 3rd highest percentage of children in the country, aged 6-17 receiving special education services. While physicians and hospitals have noted an increase in the number of babies born with substance exposure over the past 5 years, the data is anecdotal. The DHHR and the WV Perinatal Partnership is working to develop improved guidelines for diagnosis, reporting and capturing of this data to improve service provision for this population. West Virginia has the 7th highest percentage of low-birth weight births in the nation at 9.5%, and it ranks 1st in the country in low-birth weight births among

white women (9.4%). In 2012, substance abuse was identified as contributing to abuse in 29.9% of West Virginia Coalition Against Domestic Violence cases.

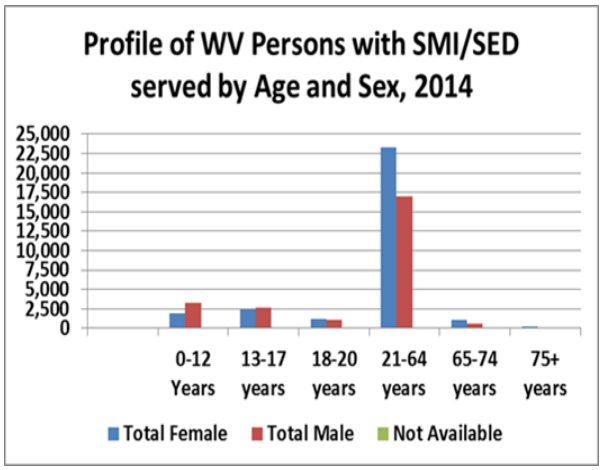
According to the AFCARS 2013 Foster Care Data File, WV ranks higher than the national Average (31%) for substance use as a reason for removing children from the home and the third highest in the nation for child removal from parents' custody with parental alcohol and or drug use as a reason for removal at a rate of 52.7%. In 2012, WV had a suicide death rate of 17.6 (4.7 above the national rate) ranking 11th in the Nation for all ages combined. According to the Centers for Disease Control and Prevention those rates decreased to 16.4%. The U.S. Department of Justice (DOJ) recently assessed the "system of care for children with mental health conditions" and the letter concluded that "West Virginia fails to provide services to children with significant mental health conditions in the most integrated settings appropriate to their needs in violation of the ADA. The State has needlessly segregated thousands of children far from family and other people important in their lives. With adequate services, the State could successfully treat these children in their homes and communities. The systemic failure to develop critical in-home and community-based mental health services also places children with mental health conditions who currently live in the community at risk of unnecessary institutionalization."

The DOJ report provided a series of recommended remedial measures, including expanding in-home and community-based mental health service capacity; eliminating unnecessary use of segregated residential treatment facilities (it may be worth noting that there are no state-operated children's hospitals or residential treatment facilities in West Virginia); ensuring that the CBHCs provide for (directly or indirectly) in-home and community-based mental health services across the state using evidenced-based approaches; designating a single Intensive Care Coordinator to coordinate cases where a child is involved in multiple child-serving systems; developing an interagency decision making and oversight entity to improve coordination of and access to intensive mental health services; modifying policies and practices to ensure the effective engagement of families as full partners in the assessment, planning, and implementation of services and supports; providing families, children and youth with accurate, timely, and accessible information regarding the services available in their communities; developing and implementing a cross-system remedial plan; and, assessing each individual placed in segregated residential treatment facilities by or funded by DHHR. The Bureaus of Behavioral Health and Health Facilities, Child and Family Services and Medicaid are already engaged in developing solutions and were in the process of implementing the *Safe at Home* program prior to the review.

The SAMHSA Barometer also found that In West Virginia, about 83,000 adults (5.8% of all adults) per year in 2009–2013 had Serious Mental Illness within the year prior to being surveyed, higher than the national average. In West Virginia, about 10,000 adolescents (7.9% of

all adolescents) per year in 2009–2013 had at least one Major Depressive Episode within the year prior to being surveyed. The percentage did not change significantly over this period. West Virginia's percentage of MDE among adolescents was similar to the national percentage in 2012–2013.

In West Virginia, about 74,000 adults (5.2% of all adults) in 2009–2013 had serious thoughts of suicide within the year prior to being surveyed. The percentage did not change significantly over this period. The percentage did not change significantly over this period. West Virginia's percentage of adults with suicidal thoughts was higher than the national percentage in 2011-2013. According to data collected by the Bureau for Behavioral Health and Health Facilities the total number of individuals served with SMI/SED was 54,566 for all ages.



BUILDING ON A SUCCESSFUL DATA DRIVEN PLANNING PROCESS

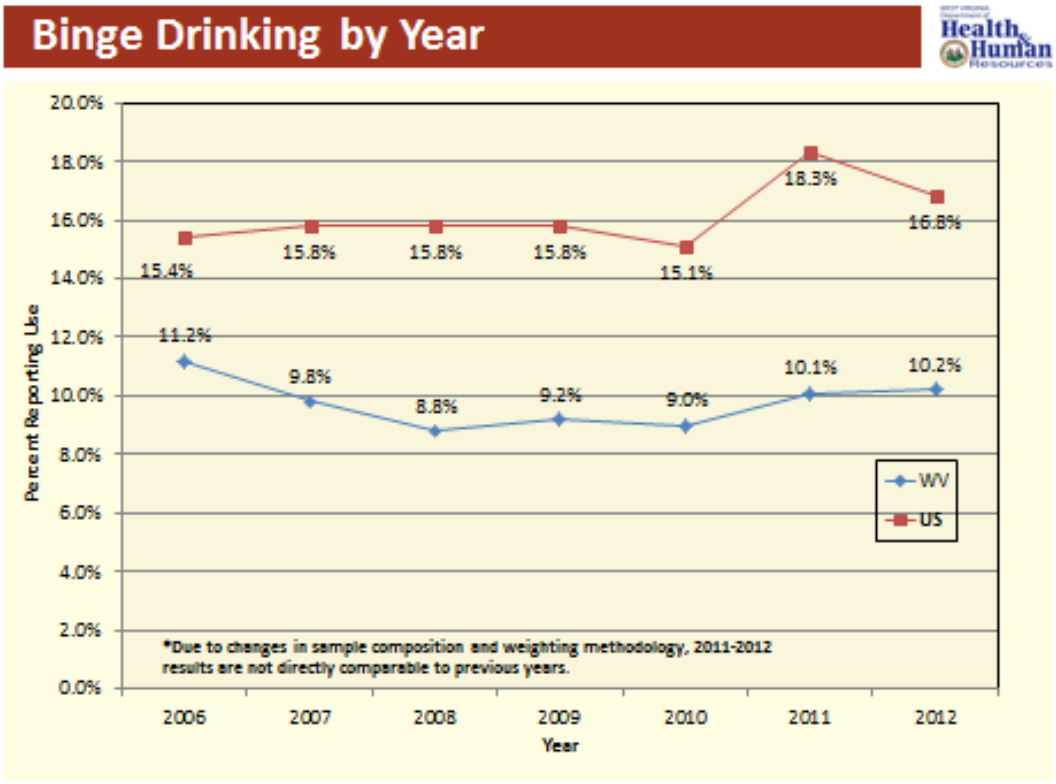
The Bureau for Behavioral Health and Health Facilities has continued to provide updates to the the initial strategic planning processes initiated in 2010, to assess the statewide service needs for children and adults with substance use and mental health disorders and intellectual and developmental disabilities. The BBHHF meets regularly with colleagues and critical partners to inform planning and funding decisions for delivering services and supports (e.g. behavioral health providers, consumer and family planning and advocacy groups, and people who work in the field of traumatic brain injury).

The Governor's Advisory Council on Substance Abuse has met face to face nine times, and the RTFs in each of the six regions have held 16 rounds of meetings (96 local meetings statewide), with almost 4,000 people attending and participating. During both stakeholder and regional meetings, members identified gaps in the array of service delivery, gained information about various topics related to Prevention, Early Intervention, Treatment, and Recovery, and recommended priorities for strategies and allocation of resources. The GACSA assimilated information gathered at the local level with state and regional data to report progress and recommendations to the Governor each year. The outcome of these activities has resulted in significant changes in legislative policy, service availability and delivery, an addition of $10 million in funding, shared resources, and collaboration. This top down, bottom up approach for

policy, planning and partnerships is West Virginia's preferred model for planning and allocation of all behavioral health funds.

Substance Abuse Related Prevalence Data (This data is based on needs considered or planning)

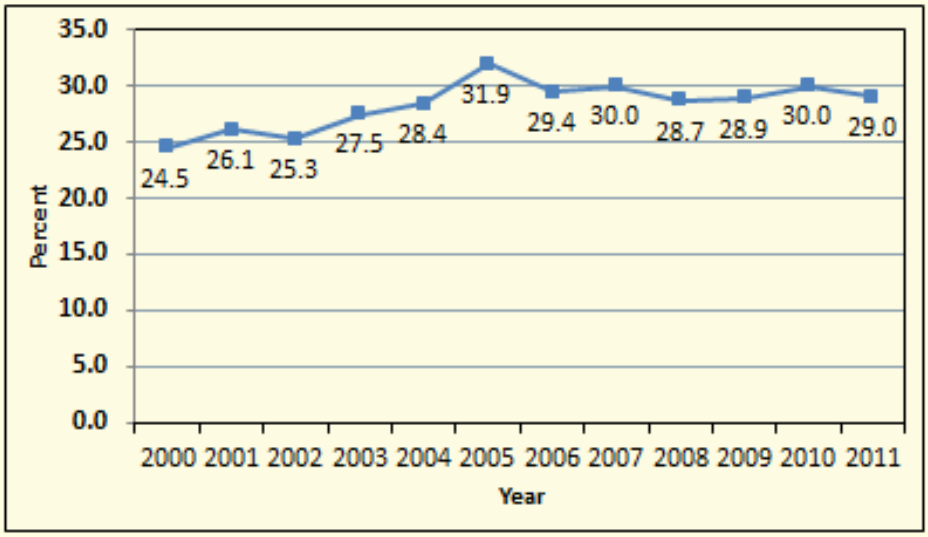
- Alcohol-2nd highest in the nation for binge drinking intensity (9 or more drinks per episode)
- In 40% of fatal automobile accidents, alcohol was a factor



- While smoking rates have decreased for youth in WV, pregnant women smoke more than those individuals who smoke in the general population.

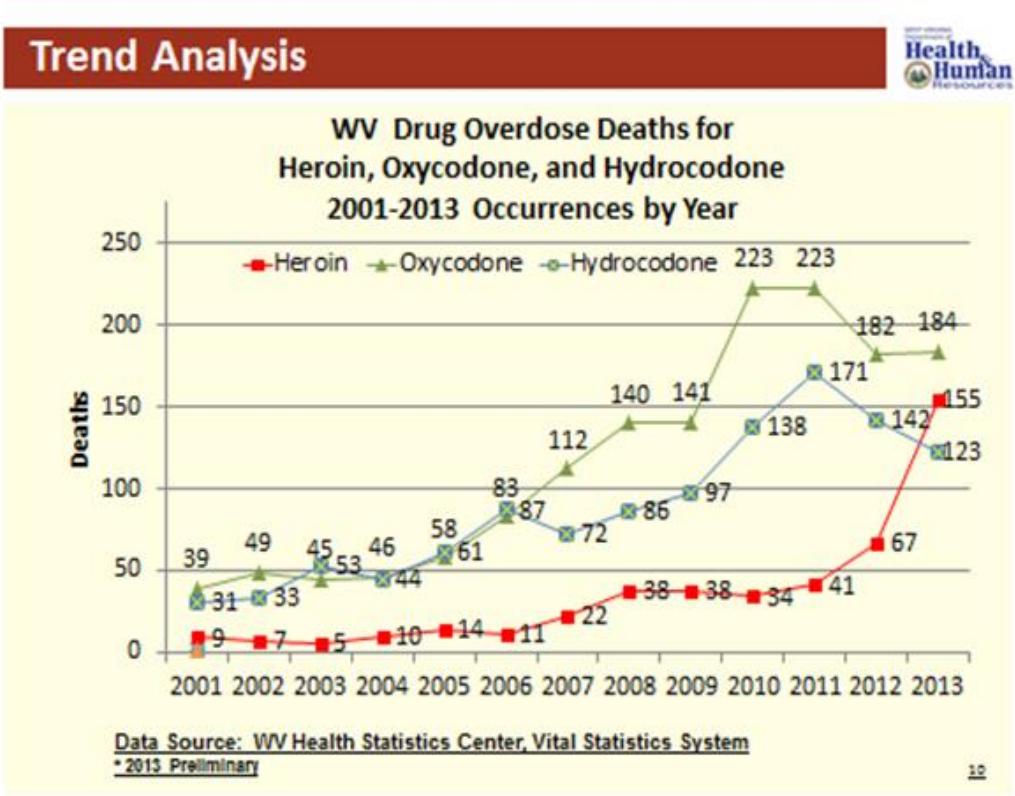
Tobacco

Pregnant women in WV reporting any smoking during the last three months of pregnancy

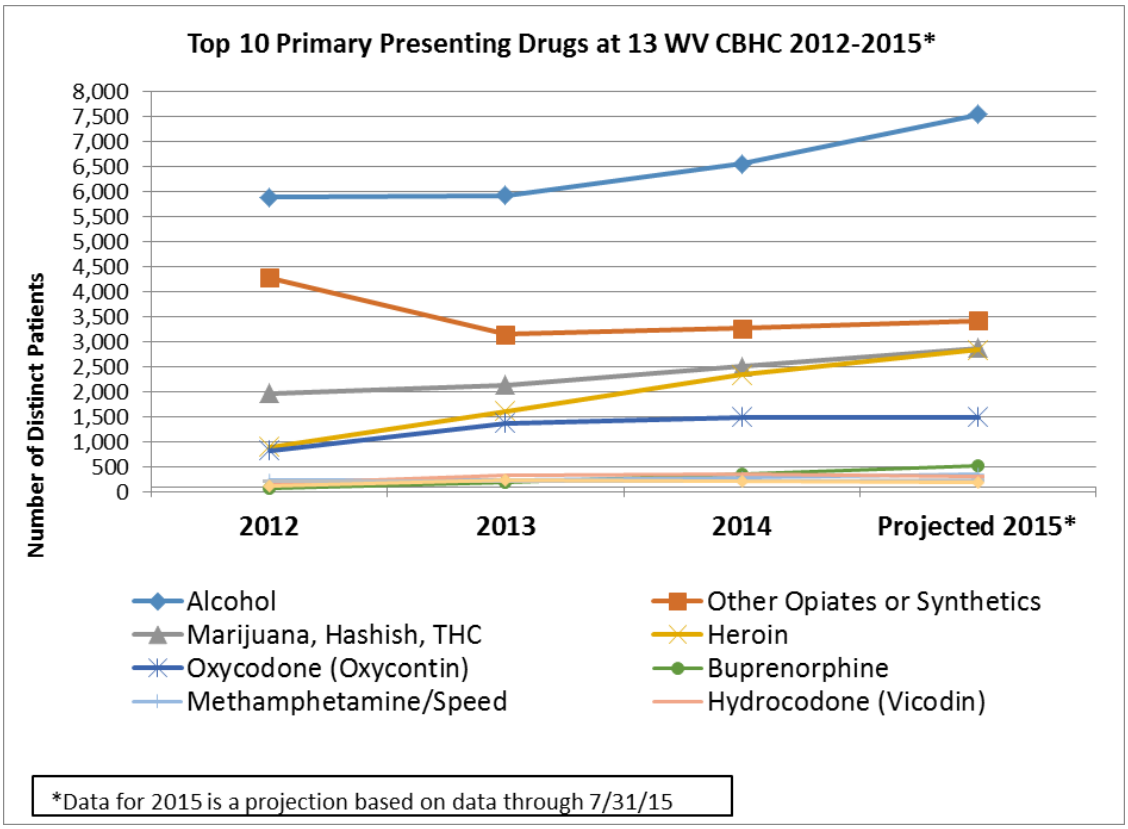


Source: Pregnancy Risk Assessment Monitoring System

- Highest rate of prescription drugs filled in the United States
- As of August 21, 2014, filed death certificates list 258 total overdose deaths, of which 79 are oxycodone related, 58 are hydrocodone related and 57 are heroin related
- Drug overdoses now kill more West Virginians each year than car accidents do. It's the leading cause of accidental deaths in the state
- While prescription drugs have decreased as the cause of overdose deaths, Heroin rates have increased steadily since 2001. Unpublished data continues to show increases through 2015



- The top presenting drug across all years at the 13 WV Comprehensive Behavioral Health Centers was alcohol. The number of patients presenting with alcohol as their primary drug has increased an estimated 28% from 2012 to projected 2015 numbers (based on data through 7/31/15).
- Heroin as the primary presenting drug at the 13 WV Comprehensive Behavioral Health Centers has increased an estimated 215% since 2012, from 903 to an estimated 2,841 cases. Buprenorphine, although smaller in absolute numbers, has shown the greatest percentage increase since 2012 – an estimated 564%.
- The only category of presenting drug that has shown a decrease since 2012 is "Other Opioids and Synthetics," which may reflect the decreased use of synthetics due to tighter regulation, enforcement and increased education.



- Although WV has shown a 12% increase in Hepatitis B cases from the first half of 2014 to the first half of 2015, several counties have been identified as "hot spots," with a much larger percentage increase than the state as a whole. Care must be taken in interpreting these data, as the actual number of cases in several counties is quite small. Also, please note that these numbers are provisional, and may change as new information becomes available to public health. This is just a snapshot of the data over time, and there are many factors that can affect the number of cases that are reported
- It may also be possible that, with the recent interest in WV's hepatitis problems, with several proposed remedies such as needle exchange programs, and with new hepatitis treatments being advertised in the media, that the number of tests that have been performed has increased. If that is the case, the increase in case counts could be a product of increased surveillance efforts, and may not necessarily indicate an increase in disease incidence

Hepatitis B "Hot Spots": WV Counties with the Greatest Percentage Increase, First 26 Weeks of 2014 vs. 2015

County	First 26 Weeks 2014	First 26 Weeks 2015	Percent Increase
Cabell, WV	10	27	170.0%
Harrison, WV	4	10	150.0%
Jackson, WV	1	7	600.0%
Kanawha, WV	31	47	51.6%
Logan, WV	5	10	100.0%
Wood, WV	2	9	350.0%

Other Substance Abuse Related Indicators

- 1 in 4 individuals experiencing homelessness reported a mental illness and/or substance abuse issue
- 32% of domestic violence survivors identified alcohol as a contributing factor
- The major causes of disability in the U.S. are changing from medical to social and behaviorally-related conditions, increasingly involving complications such as substance abuse, violence, and poor mental health
- According to the Hartley Funded Services Progress Report, Between 2010 – 2013 a total of 8,845 individuals were committed to State Hospitals

PROGRESS REVIEWED AND CHALLENGES DETERMINED

West Virginia has made considerable progress in comparison to previously identified needs by adding programs and supports for all populations as noted in Step 1. The following service gaps continue to be identified as new challenges emerge:

Program Challenges

- Lack of dissemination of Nalaxone for use by law enforcement, family members and communities at large due to barriers of cost, availability in pharmacies, and preference for using the Evzio device vs. the method (syringe) that is currently covered by Medicaid
- Short-Term Residential Treatment Programs for Pregnant Women and Transitioning Youth are not available in every region of the State

- Lack of acceptance in recovery community and some provider groups for Medication Assisted Treatment
- State standards and monitoring do not exist for MAT physicians that are not Medicaid providers
- Lack of MAT services in primary care and behavioral health centers particularly for pregnant women
- Lack of services for children with significant mental health conditions in the most integrated settings appropriate to their needs
- Inconsistent protocols and guidance on diagnosis and referral for women using substances
- A Women's Recovery Network does not exist
- As recovery facilities expand for women without any in-house clinical staff there are increased technical assistance needs regarding protocols for accepting and caring for the children that may be substance exposed or have trauma associated issues
- Inconsistent cross-system service resource sharing particularly with individuals with complex needs
- Drop-In Centers are currently located regionally but not accessible at the local level
- Supportive service shortages areas include: transportation, mobile crisis services, and peer recovery support groups particularly for medication assisted recovery and youth in recovery

Work Force Challenges

- Only 50% of Prevention Specialist are certified through IC& RC
- Lack of Child Psychiatrist and clinical staff providing best practices for youth and young adults
- Insufficient number of Credentialed and Licensed Counselors to provide therapy in coordination with Physicians providing medication assisted treatment
- Barriers continue for individuals in recovery entering the workforce
- Physician best practice in prescribing still not implemented including reporting to the PDMP and Universal Screening of Pregnant Women
- Implementation of the Community and Peer Certification Process
- Behavioral health education courses are limited in community and technical schools

Innovative System Infrastructure Challenges

- Telehealth is limited across provider organizations particularly with regard to screening and treatment service provision particularly youth, pregnant women, and individuals living in rural areas of the State
- Lack of home-based solutions

- Cross-system collaborations and information sharing are necessary for data collection, program service definitions and population program development
- Social media and marketing is inconsistent across agencies and organizations to increase public education messaging and service engagement
- On-site program monitoring standards are inconsistent to reinforce the utilization of best practices and quality standards
- Lack of standardized quality measures for consumers to review programs
- Antiquated business practices continue to inhibit sustainability and overreliance on federal and state funding (partnerships, grant-writing capacity, funding diversification)

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG Quality and Data Collection Readiness Narrative

1. The BBHHF Data and Technology Team capture behavioral health episodic utilization data from the State's thirteen comprehensive service providers in coordination with APS Healthcare, the State Medicaid Authority's Utilization Management contractor. Providers submit information to APS Healthcare regardless of payer source for all services provided. In addition to capturing client services data and demographic data for all consumers served, APS Healthcare uses clinical information submitted for Medicaid-eligible consumers to provide prior authorization approvals for requested services. The organization uses aggregate data and individual agency data to develop technical assistance for providers to improve outcomes and for quality improvement.

   The BBHHF data reporting system collects client data containing demographic data, services provided, and information for federal and state reporting, such as Treatment Episode Data Set (TEDS), Block Grant Reports and URS tables.

   These report both duplicated and non-duplicated counts of persons in a variety of demographic groups, such as age, gender, race, disability group (MH, SA, IDD), employment status, housing status, funding (Medicare, Medicaid, or private pay), service locations (i.e., in-state psychiatric hospitals, community setting, group homes), legal and drug involvement.

   These data are also used to report back to providers the number of records sent each day, the number of persons served this year, and quality issues, such as missing or unexpected changes in data (date of birth). Logic validations are also used (i.e. Age<14 and divorced, married, widowed).

2. The BBHHF data and collection reporting system collects data relating to both substance abuse and mental health services clients. This data is collected for the 13 Comprehensive Health Services clinics in West Virginia. The BBHHF does not collect data on the non-comprehensive clinics.

3. The BBHHF is able to collect and report on measures at the individual client level, but only for the 13 Comprehensive Clinics served by the state. The BBHHF data reporting system collects client data containing demographic data, direct services provided, and information for federal and state reporting, such as Treatment Episode Data Set (TEDS), Block Grant Reports and URS tables.

4. To be able to report on all clients, including those not served by the 13 Comprehensive Clinics, the BBHHF would need to incorporate a data collection system that includes data for support services and non-comprehensive providers. West Virginia DHHR/BHHF

is currently considering two possible approaches to collection and reporting of ALL grantees/providers. These two approaches are described below. However, a time for delivery of either model has not yet been determined.

a. Internal development of a client level data collection model for ALL state providers. This approach would provide for data collection and reporting of all client level data but would be external to the State's current fee-for-service model. Providers would be provided with a client-server application to submit client level data, demographics, and service data.

b. Expansion of the State's existing Utilization Management contract expanding data collection to include non-comprehensive providers and support services following a model similar to that used for the comprehensive providers. This approach is an optional part of a developing Request For Proposal (RFP) currently underway.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention of Substance Abuse and Promotion of Good Mental Health

Priority Type: SAP, MHS

Population(s): SMI, SED, PWWDC, PP, IVDUs, HIV EIS, TB

Goal of the priority area:

Promote emotional health and wellness, prevent or delay the onset of complications from substance abuse and mental illness, and identify and respond to emerging behavioral health issues

Objective:

1. Prevent and reduce attempted suicides and death by suicide among populations at risk
2. Integrate Prevention and Promotion efforts statewide to reduce substance use and promote good mental and physical health
3. Improve response time to emerging trends and timely data sharing

Strategies to attain the objective:

1-1. Create safe and supportive environments through anti-stigma awareness and education
2. Integrate the suicide prevention call line with the new behavioral health call line
3. Require suicide prevention training and intervention strategies in all provider grants
2-11. Offer cross-training and networking opportunities for “prevention” and “promotion” providers in each county to increase collaborative planning efforts
2. Implement evidenced-based programs and practices shown to promote good mental health and prevent substance use/abuse
3. Strengthen community mobilization efforts by promoting inclusion of additional sectors in existing coalitions and marketing services
4. Support youth-led organizations to provide consistent prevention/promotion messages and create positive alternatives for youth that develop leaders
5. Increase the number of environmental strategies applied which focus on community norms change
6. Implement merchant education and Synar Inspections in coordination with the WV State Police, Local Prevention Coalitions and Youth representatives
7. Continue to provide community based messaging regarding the dissemination of Naloxone to law enforcement, family members and communities at large
3-1 1. Coordinate efforts with WV State Epidemiological Work Group-Early Warning Network, Regional Task Force Members, and the Prevention Network to determine new trends of substance use prevalence and method of use
2. Capture data at the zip code level
3. Produce and disseminate current data while still insuring that proper vetting occurs
4. Develop and disseminate “WV Responds”, a compilation of cross-agency effort around current “hot topics” related to behavioral health

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: substance abuse prevalence for prescription drugs

Baseline Measurement: 4.16 (12-17) 6.54 (18-25)

First-year target/outcome measurement: 2% decrease in prescription drug use

Second-year target/outcome measurement: 2% decrease in prescription drug use

Data Source:

NSDUH and School Climate Survey

Description of Data:

NSDUH federally funded randomized survey
School Climate initiated in over 50% of schools in WV

Data issues/caveats that affect outcome measures::

No issues.

Indicator #: 2

Indicator: substance abuse prevalence related to overdose deaths

Baseline Measurement: 550

First-year target/outcome measurement: decrease by 5%

Second-year target/outcome measurement: decrease by 5%

Data Source:

Bureau for Public Health

Description of Data:

Medical Examiner reporting

Data issues/caveats that affect outcome measures::

Data lag

Indicator #: 3

Indicator: rate of suicides

Baseline Measurement: 16.4 rate overall

First-year target/outcome measurement: Decrease by 2%

Second-year target/outcome measurement: Decrease by 2%

Data Source:

Bureau for Public Health

Description of Data:

Medical Examiner and Death Data

Data issues/caveats that affect outcome measures::

Time lag for verifications/ Possible inconsistencies through local coroners

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Indicator #: 4

Indicator: Synar Buy Rates

Baseline Measurement: 14%

First-year target/outcome measurement: 2%

Second-year target/outcome measurement: 2%

Data Source:

Bureau Health Statistics, Bureau for Behavioral Health

Description of Data:

Synar Report

Data issues/caveats that affect outcome measures::

Indicator #: 5

Indicator: Naloxone Distribution

Baseline Measurement: 0

First-year target/outcome measurement: 100 doses

Second-year target/outcome measurement: 100 dose

Data Source:

WVU

Description of Data:

EMS reporting and law enforcement

Data issues/caveats that affect outcome measures::

this data has not been collected and being determined as a requirement of new legislation

Priority #: 2

Priority Area: Systems Integration

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, IVDUs, HIV EIS, TB

Goal of the priority area:

Provide coordinated care and services across systems

Objective:

1. Promote a recovery-oriented service system that includes coordinated clinical treatment and recovery support services
2. Improve the physical health outcomes of individuals with substance use and mental health disorders and developmental disabilities
3. Implement a behavioral health network for youth and young adults
4. Implement a trauma informed approach across systems
5.Create behavioral health capacity in the criminal justice system
6. Provide technical assistance and foster opportunities for innovative telehealth practices
7. Increase the number of individuals who provide behavioral health services in West Virginia
8. Reduce the impact of disasters on the behavioral health of individuals, families, and communities
9. Remove financial barriers and incentivize effective care coordination and integrated service delivery for all populations

Strategies to attain the objective:

1-1. Promote the expansion of community based “close to home “crisis response systems
2. Foster providers’ ability to provide person centered care through multiple approaches
3. Create a pathway for individuals in recovery to reintegrate into communities through housing and employment
4. Provide support for the development of a Women’s Recovery Network
5. Provide technical assistance regarding protocols for accepting and caring for the children within recovery facilities that may be substance exposed or have trauma associated issues
6. Provide training for providers who employ peers in the workplace and certify recovery coaches through training
7. Provide funding that promotes home and community based services to avoid homelessness, hospitalizations and out-of-home placements
8. Increase the number of trained peer/recovery support specialists, peer run drop in centers and recovery residences/facilities
9. Provide a greater role for peers in quality assurance through developing standards and reviewing provider agencies
10. Coordinate efforts among the Governor’s Advisory Council on Substance Abuse, the Governor’s Regional Task Forces and the Behavioral Health Planning Council in order to support an integrated advisement structure
2-1. Require all behavioral health providers to screen for infectious health diseases upon intake
2. Provide funding through health screening and promotion codes to behavioral health providers to screen and address health issues that are prevalent in WV that lead to shorter lifespans for the population
3. Promote the integration of health and behavioral health among primary care and behavioral health providers
3-1. Facilitate regional cross-system stake holder meetings for all BBHHF funded providers
2. Identify and align resources across systems to meet the needs of youth, young adults and families
3. Develop a youth-led leadership team from representatives from each region of the State to plan, develop and implement evidence based programs and practices (lived experience and primary prevention)
4. Provide intensive technical assistance in engagement and best practices to Regional Youth Service Centers

4-1. Develop a statewide plan in coordination with federal technical assistance guidance to align multiple existing efforts/trainings and different levels of readiness
2. Provide intentional technical assistance to providers as assessed through readiness assessment
5-1. Provide best practice cross-training opportunities for behavioral health and criminal justice providers in the community
2. Continue to partner with the Department of Military Affairs and Public Safety to support the Justice Reinvestment initiatives by promoting and funding behavioral health treatment and recovery services to the offender population
3. Continue to provide funding for Juvenile Drug Courts and partner with Juvenile Day Report Centers
4. Continue to provide funding for Teen Courts as an early intervention strategy in all regions of WV
6-1. Partner with universities and community providers to increase telemedicine particularly with regard to screening and treatment service provision among youth, pregnant women, and individuals living in rural areas of the State
2. Provide best practice in using social media and marketing across agencies and organizations to increase public education messaging and service engagement
3. Continue to promote the use of electronic health records and software that can be used across the continuum that can improve access to care
7-1. Develop and disseminate best practice guidance aligned with service definitions and models of care
2. Provide funding and free training opportunities for individuals to become certified community support and prevention specialists
3. Coordinate efforts with universities in the integration of behavioral health content in social work, criminal justice and all allied health
4. Coordinate efforts with universities in the provision of telethealth service ability
5. Continue to coordinate the WV Integrated Behavioral Health Conference
6. Continue to provide training opportunities for physicians through the Appalachian Addiction Conference and face to face best prescriber trainings
7. Improve diagnosis and reporting of substance exposed pregnancies through training and partnership efforts
8. Implement the BBHHF Community and Peer Certification Process statewide
9. Coordinate efforts with the Higher Education Policy Commission and Rural health to include behavioral health in related courses in community and technical schools
8-1. Promote the integration of behavioral health in all state and local responses to disasters
2. Provide training with all behavioral health providers particularly new peer/recovery support staff on best practices for response and recovery
9-1. Meet regularly with state agency partners that share the same mission and serve the same population to avoid duplication of services
2. Implement health homes for children with complex support needs through an intensive wrap around process
3. Enforce more appropriate use of public funds to maximize service capacity with the implementation of Medicaid expansion
4. Partner with behavioral health providers and agencies, such as criminal justice and homeless services, sharing information to enhance readiness and providing outreach and enrollment eligibility training to ensure that individuals have and maintain health insurance
5. Submit grants to create a diversified funding balance through discretionary federal grant awards and public/private partnerships
6. In coordination with the WVSEOW, evaluate and report cost analysis/cost savings across systems (Inmate population, substance exposed pregnancies, peer/recovery supports and SBIRT)
10-1. Improve data measures for measuring consumer engagement, services and satisfaction
2. Increase and share reports from the PDMP and Medicaid systems
3. Develop and publish quality report cards for service providers
4. Conduct quarterly monitoring of BBHHF providers for funding utilization and timely redirection of unused funds

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: # of peer and recovery support specialists

Baseline Measurement: 230

First-year target/outcome measurement: 25

Second-year target/outcome measurement: 25

Data Source:

BBHHF Office Consumer Affairs and Community Outreach Data Base

Description of Data:

record of certified peer support specialists and recovery coaches

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: # of health screens for infectious disease and health issues in behavioral health centers

Baseline Measurement: 0

First-year target/outcome measurement: 600

Second-year target/outcome measurement: 600

Data Source:

BBHHF Required Monthly Provider Reporting

Description of Data:

Codes for General Health Screens

Data issues/caveats that affect outcome measures::

This is a new covered service through BBHHF that is part of a 2 year pilot.

Indicator #: 3

Indicator: # Served in Regional Youth Service Centers

Baseline Measurement: 0

First-year target/outcome measurement: 600

Second-year target/outcome measurement: 600

Data Source:

BBHHF Monthly Required Reporting

Description of Data:

youth and young adults served to show engagement of new service center of excellence

Data issues/caveats that affect outcome measures::

new program

Indicator #: 4

Indicator: # Teen Courts Statewide

Baseline Measurement: 12

First-year target/outcome measurement: increase by 6

Second-year target/outcome measurement: increase by 6

Data Source:

BBHHF Monthly Required Reporting

Description of Data:

Operational Teen Courts

Data issues/caveats that affect outcome measures::

Indicator #: 5

Indicator: # children served in health home model with complex support needs

Baseline Measurement: 0

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

Medicaid

Description of Data:

Participation data and service utilization record

Data issues/caveats that affect outcome measures::

New programs to be developed

Indicator #: 6

Indicator: # grants awarded for behavioral health programming

Baseline Measurement: 4

First-year target/outcome measurement: 1 additional plus existing continuance

Second-year target/outcome measurement: 1 additionalplus existing continuance

Data Source:

DHHR Grants Management

Description of Data:

Award letters

Data issues/caveats that affect outcome measures::

As federal grants released that are relevant to current program direction

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Indicator #: 7

Indicator: Provider Report Cards with a passing grade

Baseline Measurement: 0

First-year target/outcome measurement: 6 additional

Second-year target/outcome measurement: 13 additional

Data Source:

BBHHF Office of Consumer Affairs and Community Outreach

Description of Data:

Quality Measures to be determined to develop report card and conducted by the WV Behavioral Health Planning Council Members

Data issues/caveats that affect outcome measures::

"This is a new process to engage consumers in quality service provision

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$6,283,824		$0	$5,661,882	$20,381,271	$0	$0
a. Pregnant Women and Women with Dependent Children*	$1,877,913		$0	$0	$3,580,800	$0	$0
b. All Other	$4,405,911		$0	$5,661,882	$16,800,471	$0	$0
2. Substance Abuse Primary Prevention	$1,675,686		$0	$0	$400,326	$0	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$418,922		$0	$0	$120,000	$0	$0
13. Total	$8,378,432	$0	$0	$5,661,882	$20,901,597	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			$0	$0	$0	$0	$0
6. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
7. Ambulatory/Community Non-24 Hour Care		$2,381,856	$30,498,724	$2,272,000	$104,229,114	$0	$0
8. Mental Health Primary Prevention**		$0	$0	$0	$320,000	$0	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$132,325	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$132,325	$0	$0	$134,400	$0	$0
13. Total	$0	$2,646,506	$30,498,724	$2,272,000	$104,683,514	$0	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and specialized outpatient medical services;		
Acute Primary Care;		
General Health Screens, Tests and Immunizations;		
Comprehensive Care Management;		
Care coordination and Health Promotion;		
Comprehensive Transitional Care;		
Individual and Family Support;		
Referral to Community Services;		
Prevention Including Promotion	$1,530,000	$132,325

Screening, Brief Intervention and Referral to Treatment ;		
Brief Motivational Interviews;		
Screening and Brief Intervention for Tobacco Cessation;		
Parent Training;		
Facilitated Referrals;		
Relapse Prevention/Wellness Recovery Support;		
Warm Line;		
Substance Abuse Primary Prevention	$1,975,686	$
Classroom and/or small group sessions (Education);		
Media campaigns (Information Dissemination);		
Systematic Planning/Coalition and Community Team Building(Community Based Process);		
Parenting and family management (Education);		
Education programs for youth groups (Education);		
Community Service Activities (Alternatives);		
Student Assistance Programs (Problem Identification and Referral);		

Employee Assistance programs (Problem Identification and Referral);		
Community Team Building (Community Based Process);		
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental);		
Engagement Services	$	$656,126
Assessment;		
Specialized Evaluations (Psychological and Neurological);		
Service Planning (including crisis planning);		
Consumer/Family Education;		
Outreach;		
Outpatient Services	$	$
Individual evidenced based therapies;		
Group Therapy;		
Family Therapy ;		
Multi-family Therapy;		

Consultation to Caregivers;		
Medication Services	$	$
Medication Management;		
Pharmacotherapy (including MAT);		
Laboratory services;		
Community Support (Rehabilitative)	$	$
Parent/Caregiver Support;		
Skill Building (social, daily living, cognitive);		
Case Management;		
Behavior Management;		
Supported Employment;		
Permanent Supported Housing;		
Recovery Housing;		
Therapeutic Mentoring;		
Traditional Healing Services;		

Recovery Supports	$1,257,100	$700,000
Peer Support;		
Recovery Support Coaching;		
Recovery Support Center Services;		
Supports for Self-directed Care;		
Other Supports (Habilitative)	$	$
Personal Care;		
Homemaker;		
Respite;		
Supported Education;		
Transportation;		
Assisted Living Services;		
Recreational Services;		
Trained Behavioral Health Interpreters;		

Interactive Communication Technology Devices;		
Intensive Support Services	$	$
Substance Abuse Intensive Outpatient (IOP);		
Partial Hospital;		
Assertive Community Treatment;		
Intensive Home-based Services;		
Multi-systemic Therapy;		
Intensive Case Management ;		
Out-of-Home Residential Services	$2,877,338	$593,390
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health Services ;		

Therapeutic Foster Care;		
Acute Intensive Services	$	$
Mobile Crisis;		
Peer-based Crisis Services;		
Urgent Care;		
23-hour Observation Bed;		
Medically Monitored Intensive Inpatient (SA);		
24/7 Crisis Hotline Services;		
Other	$	$
Total	$7,640,124	$2,081,841

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$6,283,824
2 . Substance Abuse Primary Prevention	$1,675,686
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$418,922
6. Total	$8,378,432

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$128,429
	Selective	
	Indicated	
	Unspecified	
	Total	$128,429
Education	Universal	$263,361
	Selective	
	Indicated	
	Unspecified	
	Total	$263,361
Alternatives	Universal	$52,022
	Selective	
	Indicated	
	Unspecified	
	Total	$52,022
Problem Identification and Referral	Universal	$19,508
	Selective	
	Indicated	
	Unspecified	
	Total	$19,508

Community-Based Process	Universal	$785,207
	Selective	
	Indicated	
	Unspecified	
	Total	$785,207
Environmental	Universal	$377,159
	Selective	
	Indicated	
	Unspecified	
	Total	$377,159
Section 1926 Tobacco	Universal	$50,000
	Selective	
	Indicated	
	Unspecified	
	Total	$50,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	$0
Total Prevention Expenditures		$1,675,686
Total SABG Award*		$8,378,432
Planned Primary Prevention Percentage		20.00 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$1,675,659	
Universal Indirect		
Selective		
Indicated		
Column Total	$1,675,659	
Total SABG Award*	$8,378,432	
Planned Primary Prevention Percentage	20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	þ
Tobacco	¢
Marijuana	þ
Prescription Drugs	þ
Cocaine	¢
Heroin	þ
Inhalants	¢
Methamphetamine	¢
Synthetic Drugs (i.e. Bath salts, Spice, K2)	¢
Targeted Populations	
Students in College	þ
Military Families	þ
LGBT	þ
American Indians/Alaska Natives	¢
African American	¢
Hispanic	¢
Homeless	¢
Native Hawaiian/Other Pacific Islanders	¢
Asian	¢
Rural	¢
Underserved Racial and Ethnic Minorities	¢

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$5,000	$20,000	$0	$25,000
2. Quality Assurance	$0	$0	$0	$0
3. Training (Post-Employment)	$5,000	$20,000	$0	$25,000
4. Education (Pre-Employment)	$0	$0	$0	$0
5. Program Development	$5,000	$20,000	$0	$25,000
6. Research and Evaluation	$5,000	$20,000	$0	$25,000
7. Information Systems	$5,000	$20,000	$0	$25,000
8. Total	$25,000	$100,000	$0	$125,000

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	
MHA Planning Council Activities	$47,569
MHA Administration	$132,325
MHA Data Collection/Reporting	
MHA Activities Other Than Those Above	$2,053,667
Total Non-Direct Services	$2233561
Comments on Data:	

Footnotes:

MHA Activities Other Than Those Above includes funding to providers for drop-in centers, day programs, outreach, suicide prevention council, and peer support services.

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be charged with coordinating care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 1. Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. **Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?**

As noted previously, West Virginia elected to expand Medicaid. As of January 1, 2016, expanded coverage will be identical to current coverage for all Medicaid members. New members will be eligible at 138% of the FPL and will be eligible for all M/SUD services currently covered as detailed in the Medicaid Providers' Manual. Medicaid provider manuals for MH/SUD can be found at: http://www.dhhr.wv.gov/bms/Pages/Manuals.aspx

According to CMS' State of West Virginia Website, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/west-virginia.html , the participation rate is the percentage of eligible children enrolled in Medicaid and CHIP in the state. Data from 2013 show 88.3 percent of the eligible children in the United States are enrolled in Medicaid and CHIP programs and West Virginia's participation rate is above the national average at 91.6%.

West Virginia's Essential Health Benefit Benchmark plan is based on Highmark Blue Cross Blue Shield of West Virginia's Super Blue Plus 2000 PPO, which includes outpatient and inpatient Mental/Behavioral Health and Substance Abuse Disorder as well as prescription drug coverage.

Because West Virginia dos not operate its own Marketplace, enrollment assistance and Qualified Health Plans in West Virginia can be found at: https://www.healthcare.gov/ or via the WV Offices of the Insurance Commissioner http://bewv.wvinsurance.gov/

According to a March 2015 U.S. Department of Health & Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation Issue (APSE) Brief, 33,421 people enrolled in private plans through the West Virginia exchange during the 2015 open enrollment period (through February 22). 86 percent qualified for premium subsidies, and 49 percent are new to the exchange for 2015. The other 51 percent are people who had plans in 2014 and either renewed them or selected a different exchange plan for this year.

West Virginia still has just one carrier in its exchange, Highmark Blue Cross Blue Shield, which has 14 plans available this year. According to an article by Sarah Tincher in the January 10, 2015 edition of The State Journal, *Affordable Care Act expands WV health care* , while "the average number of health insurance issuers in the Marketplace per state increased from five to seven between 2014 and 2015, with 21 of the 35 states having at least five issuers, while Michigan and Ohio both have 16 . . . West Virginia, however, is the only state offering only one issuer . . . which limits the health plan options for residents."

2. **Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?**

In West Virginia if an individual or family is unable to access services offered through QHPs or Medicaid the thirteen (13) Comprehensive Behavioral Health Centers can access BBHHF's State funded charity care dollars. As the program leadership team reviews allocation on an ongoing basis, the team will see

where these funds are being spent. From this use of State Funding, the team will know what is not being funded through the QHP and Medicaid.

3. **Who is responsible for monitoring access to MH/SUD services by the QHPs? Briefly describe the monitoring process.**

The Rates & Forms Commission within the Offices of the Insurance Commissioner (OIC) reviews plans when they are filed and verifies that MH/SUD services are provided. The plans are certified and become QHPs if they meet all of OIC's requirements. The plans must re-certify annually and again it is verified that MH/SUD services are provided. At any time, if there is a complaint regarding coverage, the OIC investigates and plans risk losing their certification if MH/SUD services are not provided as detailed in their submitted plan. Plans are not monitored within the year unless there is a complaint.

According to the West Virginia Offices of the Insurance Commissioner, "West Virginia Code Section 33-25A-12 states that HMO's must maintain a grievance procedure by which enrollees (or their authorized representatives) may report grievances with respect to any provisions of the HMOs' health maintenance contracts. West Virginia Code Section 33-25A-12(4) further states that each HMO must submit to the Commissioner an annual report in a form prescribed by the Commissioner which describes its grievance procedure and contains a compilation and analysis of the grievances filed, their disposition, and their underlying causes. A description of the HMO's grievance procedure must be attached to the Annual Grievance Report form. The form for this report is Attachment A to this Informational Letter. Each HMO must complete this form to account for all matters handled through its expedited and formal grievance procedures, and attach additional information and/or explanations on a separate sheet of paper. The report must cover all enrollees of the HMO, including PEIA and Medicaid enrollees. However, the report is not required to cover Medicare and Administrative Services Only ("ASO") enrollees. The completed report and a description of the grievance procedure are due on or before March 1st following the end of the calendar year covered by the report. An HMO will be required to submit a corrective action plan if it receives ten (10) or more confirmed complaints regarding any of the above listed categories within a reporting period. Written plans of action will be submitted for semiannual calendar year periods (e.g. January– June, July-December)."

In addition, according to the West Virginia Offices of the Insurance Commissioner, the Office of Consumer Advocacy "protects consumer's insurance interests by investigating alleged violation of state consumer protection laws, taking appropriate legal action to stop unfair or deceptive practices in the marketplace and promoting consumer education and awareness. The Office works to ensure that consumers are provided with insurance services meeting acceptable standards of quality, equity, and dependability at fair rates by enforcing insurance laws and providing consumer protection awareness. Any suspected violation of West Virginia laws or regulations is forwarded to the Insurance Commissioner for enforcement.

In West Virginia, a formal complaint can be filed with the West Virginia's Offices of the Insurance Commissioner's Consumer Service Division. If a solution can not be reached the Consumer Advocate may provide legal representation on behalf of the consumer at administrative hearings arising from the consumer complaints."

According to the West Virginia's Offices of the Insurance Commissioner's 2013 Annual Report, the Office of Consumer Advocacy "assisted consumers with 105 complaints during 2013, yielding financial awards

totaling $800,665.50 directly to consumers . . . The Consumer Service Division assists our insurance consumers with questions and complaints. The division received a total of 1,942 written complaints from insurance consumers in 2013. Over the course of the year, the Division responded to an average of 100 consumer inquiries per day."

4. **Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?**

The Bureau of Medical Services (BMS), a sister bureau within the Department of Health and Human Resources (DHHR), typically receives complaints of this type as BMS' Behavioral Health Services Manager handles behavioral health services for BMS. BMS reports that they first call the provider to investigate the complaint. If they determine that there has been a violation, they notify the provider both by phone and by letter that the violation must be remedied and must not recur. Should they then receive a subsequent complaint, an auditor will be sent out to the provider location and a formal infraction will be documented. The provider is then required to complete a plan of action for correcting the situation. Conversely, if the complaint is found to be invalid, the complaint is closed and the consumer is advised of the finding in writing. As BBHHF and BMS are sister bureaus within DHHR, while the SMHA and SSA will not be directly involved in reviewing the complaint unless their expertise is needed, both will be notified of the complaint and the resolution after the fact.

In addition, the Office of Consumer Affairs and Community Outreach has received a number of complaints about service denials potentially in violation of MHPAEA, primarily involving recurrent physician prescriber issues with a given MCO not covering Medication Assisted Treatment beyond a time-limited period and connecting them with written educational resources and consumer rights guides, such as those made available by the Legal Action Center in New York.

5. **What specific changes will the state make in consideration of the coverage offered in the state's EHB package?**

BBHHF has realigned its state general revenue and federal block grant funding to assure that its limited dollars are only used for evidence-based and promising approaches to care that are not reimbursable by Medicaid or private health insurance. In West Virginia this ranges from recovery supports to supported housing. This has involved ongoing discussion and planning meetings with grantee provider agencies in order to allow for them to make the internal changes needed to capture fee for service rather than grant funding in the coming federal and state fiscal year.

6. **Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?**

In August of 2011, the Commissioner of the Bureau for Medical Services announced a stakeholder meeting to discuss a West Virginia State Plan Amendment to address Health Homes for Medicaid members. Now, four years later, the Bureau for Behavioral Health and Health Facilities has had two representatives well versed in mental health and substance abuse actively participating in the weekly team meetings for developing the first Health Home.

The first State Plan Amendment addresses Bipolar Disorder (SMI) with a secondary focus on Hepatitis C. West Virginia has one of the highest Hepatitis C rates in the country and Bipolar Disorder often results in consumers neglecting their health and discontinuing their medication. Both can have negative results and lead to excessive hospitalizations and unnecessary personal anguish and medical costs.

The initial State Plan Amendment has rolled out Health Homes in the six (6) counties in West Virginia that have the highest rates of Bipolar Disorder as well as Hepatitis C. These 6 areas also have the most advanced CBHCs and FQHCs with existing partnerships already in place so that the Health Homes can "hit the ground running". The Health Home team has identified other stakeholders in the six county region interested in participating in the Health Homes as providers.

Additionally, according to an *Open Minds News Report* dated March 15, 2015, West Virginia Medicaid to Integrate Behavioral Health into Managed Care By July 2015 - "West Virginia Medicaid is preparing to integrate specialty behavioral health services into managed care for non-disabled beneficiaries by July 2015. Currently specialty behavioral health services for all Medicaid beneficiaries are reimbursed on a fee-for-service (FFS) basis and are carved out of the Medicaid Mountain Health Trust managed care organization (MCO) capitation rates. The shift to integrate behavioral health services affects the Medicaid expansion population and adults and children eligible for Temporary Assistance for Needy Families (TANF). For both populations enrollment in managed care is mandatory . . . Currently in the FFS behavioral health system, DHHR contracts with APS Healthcare to act as an administrative services organization (ASO). The contract with APS Healthcare will continue after specialty behavioral health services are integrated into the Mountain Health Trust MCO capitation rates because MCO enrollment is not mandatory for beneficiaries with disabilities."

The MCOs under contract with BMS are Coventry Health Care of West Virginia, The Health Plan of the Upper Ohio, Unicare, and West Virginia Family Health. The name of the program is Mountain Health Trust.

BBHHF has actively participated in planning meetings held between the Bureau for Medical Services, APS Healthcare, the four regional Managed Care Organizations (MCOs) and the West Virginia Behavioral Health Provider's Association (WVBHPA - the trade organization for the 13 CBHCs and other providers) to discuss development of the MCO behavioral health provider organization networks, how care will be coordinated within the managed care context, the appeals and prior authorization processes and how behavioral health services will be rolled into managed care beginning July 1, 2015. Data collection, prior authorization, provider enrollment and other issues were discussed both at this series of meetings and at separate data specific meetings held between DHHR agency staff and representatives of the WVBHPA.

7. Is the SSA/SMHA working with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?

BBHHF has also been hosting meetings with the West Virginia Primary Care Association and several of its member agency representatives (each of whom oversee Federally Qualified Health Centers) that have been recipients of Health Resources and Services Administration (HRSA) Behavioral Health Integration grants to discuss the state behavioral health system, integration issues and coordination with primary care centers. West Virginia has a total of 10 FQHCs that received HRSA grant funding in 2014 to add or expand access to mental health and substance abuse services and BBHHF reached out to each of them offering technical assistance and support. In addition, BBHHF's former SBIRT Director has been providing as requested SBIRT training to staff of the FQHCs which received HRSA Integration grants and providing the aforementioned technical assistance on behavioral health screening and linkage with (both brief and ongoing) treatment services.

West Virginia has behavioral health integration (behavioral health in primary care) as well as reverse integration programs (primary care in community behavioral health centers) around the state. While the two modalities have different goals, both are critical to the well-being of West Virginia citizens.

Reverse integration (so called, as it is the opposite of the original Kaiser Permanente model) establishes healthcare providers in behavioral health settings, recognizing that persons with SMI die 25 years earlier than those without SMI. Two of West Virginia's largest comprehensive behavioral health centers (CBHCs) have partnered with Federally Qualified Health Centers (FQHCs) to place medical teams in their facilities. The medical teams address the issues people with SMI are known to exhibit; namely hypertension, diabetes, obesity and cardiovascular diseases. Chronic Obstructive Pulmonary Disease (COPD) is also a serious issue in West Virginia as a whole and people with SMI are no exception. Testing and treatment for pulmonary issues are also handled by the medical team embedded in the CBHCs.

Behavioral health integration was advanced in West Virginia beginning five years ago with the West Virginia Screening Brief Intervention and Referral (SBRT) grant. West Virginia designed the WSBIRT program to place behavioral health providers in FQHCs to focus on prevention and early intervention of both substance misuse and mental health issues. The program was also intended to strengthen collaboration between the FQHCs and the CBHCs. WV SBIRT has achieved exactly that, now boasting fifty-eight (58) sites around the state. With behavioral health providers in primary care settings, screenings for substance misuse and mental health issues, such as depression and anxiety, allow for prevention and early intervention for these critical health issues. WV SBIRT has been an enormous success and is now advocated for by the Governor's Advisory Council on Substance Abuse, with State funds now enabling expansion of this federally funded initiative.

Finally, BBHHF and the West Virginia Council of Churches have continued to collaborate on mechanisms to address the economic crisis and substance abuse issues that are strongly impacting our state. Recently, BBHHF and the Council of Churches held six ICISF Pastoral Crisis Invention Trainings in Wheeling, Martinsburg, Bluefield, Parkersburg, Huttonsville, and Charleston. Over 155 people were in attendance and another training is scheduled for August 24 and August 25 in Logan. A spiritual care laity registry is being developed once the required trainings (including NIMS) have been completed. The trained clergy will be able to augment the disaster behavioral health teams during times of crisis, which includes supporting impacted communities with the provision of outreach, resource linkages, and support groups as a means to build stronger local economies and community resiliency. The BBHHF will continue to build networks and coalitions of partners from non-profit, governmental, congregations, educational, responders, service, and faith based organizations to address the emotional, behavioral, spiritual, and financial impacts of the affected such as the unemployed, commerce, workforce, and the rise in behavioral such as depression, suicide, substance abuse, and domestic violence.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?

Mildred Mitchell-Bateman and William R. Sharpe Hospitals have both been smoke free facilities for a number of years now. Smoking cessation classes, patches and gum are available to patients of both state psychiatric hospitals and both facilities have 100% smoke free building and indoor area policies in place.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

Tobacco screening is done primarily at Federally Qualified Health and Free Clinics in West Virginia, although, as noted above, several of the regional CBHCs have adopted health screening and subsequent patient engagement as a result of their enhancing their relationships with primary care providers, primarily resulting from the state's SAMHSA-funded SBIRT grant.

10. Indicate tools and strategies used that support efforts to address nicotine cessation.

• Regular screening with a carbon monoxide (CO) monitor

• Smoking cessation classes

As noted above, Smoking cessation classes, patches and gum are available to patients of at the two state psychiatric hospitals and both facilities have 100% smoke free building and indoor area policies in place.

• Quit Helplines/Peer supports

The Bureau of Public Health, Division of Tobacco Prevention uses grant funds to support the WV Tobacco Quitline, managed by beBetter Networks, www.bebetter.net, which has operated since July 2000. According to the website, since that time the Quitline has enrolled over 73,000 West Virginians for Quitline services.

Finally, a number of the state's peer support programs offer Wellness Recovery Action Planning which can encompass quitting smoking using peer support along with other wellness oriented activities.

• Others_____

The tobacco free pregnancy initiative educates those who are pregnant, as well as women of child-bearing age, on the dangers of using tobacco and educates healthcare providers about the urgent need for face-to-face tobacco cessation counseling.

The Save Face-Stop Spit Tobacco Program is an educational program overseen by the WVU School of Dentistry which addresses the high rate of spit tobacco use in West Virginia.

In collaboration with the Save Face Program, the ABOUT FACE Program addresses spit tobacco for the military and their families. Up to 70% of West Virginia's military families have at least one member using spit tobacco. The ABOUT FACE Program reaches out to veterans, active military and the WV National Guard and their families.

11. The behavioral health providers screen and refer for:

• Prevention and wellness education;

• Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,

• Recovery supports.

Health Promotion and Wellness activities are supported by state Continuum Enhancement funds, which are allocated to the state's 13 regional CBHCs to use for health education and screening activities. This funding supports the development and provision of services and activities that are not otherwise billable

through other funding streams or that exceed any approved service limits or caps Each of the 13 regional CBHCs carry out these activities in somewhat different ways though, some by partnering with other community agencies in health screening events, some by conducting these activities on site at their own clinics, with subsequent linkage and referral to primary health care providers, and one or two via on site provision of health care through co-located primary care services. For example, one of the CBHCs grant agreement notes that the agency "works with other community agencies including participating in general screenings including HIV/TB/ Hepatitis, community referrals and Screening, Brief Intervention, Referral and Treatment (SBIRT). All consumers receiving medication services have their height, weight, blood pressure and girth measured at each medical visit. Blood and/or urine screens are completed by agreement at local hospitals/clinics."

Also, regional recovery support programs, such as drop in and wellness centers, Recovery Coaches and residential recovery programs offer recovery supports on an as needed basis. Furthermore, BBHHF used some of it 2013 BRSS-TACS Policy Academy grant funding to offer National Council for Behavioral Health led Whole Health Action Management train the trainer training to a mix of @ 25 peers and provider staff in 2014 and those folks are using WHAM to work with peers at various locations throughout the state.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG #2 Health Disparities

1. **Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?**

   Yes, BBHHF collects and reports on a variety of information relevant to the state's behavioral health system including access, enrollment in services, types of services received, and outcomes by race, ethnicity, gender, LGBT and age. BBHHF collects information from a large number of organizations within the behavioral health system including Medicaid data and clinical and service data from our thirteen Comprehensive Community Behavioral Health Centers and other community-based providers.

2. **Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.**

   Services and activities are designed and implemented in accordance with the cultural and linguistic needs of individuals in the community. The state's cultural and linguistic competency task force and a network of health specialists have lead roles in ensuring the cultural and linguistic needs of grant participants are effectively addressed.

   A continuous quality improvement approach is used by the state's evaluation unit to analyze, assess and monitor key performance indicators as a mechanism to ensure high-quality and effective program operations. Data will be used to monitor and manage program outcomes by race, and ethnicity, within a quality improvement process. Programmatic adjustments will be made as indicated to address any and all identified issues, including behavioral health disparities, across program domains.

   A primary objective of the data collection and reporting will be to monitor/measure project activities implemented by local service providers in a manner that optimizes the usefulness of data for project staff and consumers; evaluation findings will be integrated into community-level program planning and management on an ongoing basis (a "self-correcting" model of evaluation). For example, referral to housing, follow-through with treatment services and discharge data will be reported to staff on an ongoing basis, including analyses and discussions of who may be more or less likely to enroll and possible interventions. BHHF will provide data reports to local service provider staff to identify successes and barriers encountered in the process of project implementation. These reports will support discussions of evaluation findings with local service providers, allowing staff to adjust or modify project services to maximize project success.

3. **Are linguistic disparities/language barriers identified, monitored, and addressed?**

   Yes, linguistic disparities/language barriers are identified, monitored, and addressed by BBHHF through both our Research division, dedicated Epidemiologist, and the work of the State Epidemiological Outcomes Workgroup (SEOW)

4. **Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.**

   Interpreters and translated materials are used for non-English speaking consumers as well as those who speak English, but prefer materials in their primary language.

5. **Is there state support for cultural and linguistic competency training for providers?**

   Yes, BBHHF provides support for cultural and linguistic competency training for providers through our Office of Consumer Affairs and Community Outreach. This support includes both the provision of training by BBHHF staff and the promotion of available training opportunities in the community.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding mental health and substance abuse services.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 3: Use of Evidence in Purchasing Decisions

1. **Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.** Program Leadership, Compliance and the Director of Data Services

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions? All grantees are required to use evidenced based programs included in NREPP for all prevention services and treatment providers through prevailing best practice.

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions? Yes

4. Does the state use a rigorous evaluation process to assess emerging and promising practices? If any provider is implementing an innovative practice that has evidence but not listed as an evidence based program or practice they must require approval to do so. If that is the cased, it is up to the program to evaluate the program effectiveness. All program definitions are included in statement of work.

5. Which value based purchasing strategies do you use in your state:

a. Leadership support, including investment of human and financial resources.

b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 5. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent set aside)

West Virginia's plan for the Mental Health Block Grant 5% Set Aside ($135,788.00) to address the needs of youth and young adults who present with First Episode Psychosis (FEP) is to build upon the infrastructure of Regional Youth Service Centers (R-YSCs) currently being developed statewide. Due to the limited availability of funding, the Bureau for Behavioral Health and Health Facilities (BBHHF) will supplement funding with the set aside funds to implement a pilot program for treatment and supports for FEP by building upon an already existing youth service reform plan.

The West Virginia BBHHF is the federally designated Single State Authority for mental health and substance use disorders and serves as the lead state agency for intellectual and developmental disabilities. The BBHHF operates under the auspices of the West Virginia Department of Health and Human Resources and provides funding for community-based services for persons with behavioral health needs, including those who are either uninsured or underinsured. The BBHHF's Office of Programs and Partnerships includes the Division on Alcoholism and Drug Abuse, Division of Adult Mental Health, Division of Child and Adolescent Mental Health and the Division of Intellectual and Developmental Disabilities. This structure affords West Virginia a unique opportunity for planning and integration across disabilities not only in completing a Combined Mental Health and Substance Abuse Block Application but in day to day collaborative efforts to improve the service delivery system for individuals with behavioral health needs.

West Virginia does not currently have a Coordinated Specialty Care (CSC) Program for FEP. The plan for the 5% Set Aside Funds for FY15 will be used to develop initial capacity for CSC utilizing **the early intervention/FEP components of the Early Assessment and Support Alliance (EASA)** model. EASA is a comprehensive program designed to provide early and effective treatment to individuals who have experienced a first episode of psychosis. These funds will be specifically used for planning, training and further infrastructure development. West Virginia has begun to receive technical assistance from EASA Consultants to develop and effectively implement components of EASA for the target population. West Virginia will leverage the planned services and resources of the R-YSCs and utilize the set aside to supplement additional support services needed to begin coordinated specialty care by development of a pilot program in the Northern Panhandle. The R-YSCs provide an excellent place to start given that some of the core CSC services will be provided including: outreach, individual and group therapy, and family education. West Virginia will begin implementation in FY15 starting with a pilot program in one of the state's R-YSCs and supplement services specifically targeted for young adults ages 18-24 who present with a recent diagnosis (12 months or less) of major depression, schizophrenia, and schizoaffective disorders. West Virginia continues to work collaboratively across child and adult systems to expand the full continuum of mental health and substance abuse services and recognizes that *early intervention and timely treatment is essential to meeting the complex mental health needs of transitional age youth at risk for FEP.*

Mental Illness in WV

- ⇨ *Almost 8% of West Virginians experienced at least one major depressive episode within the past year (16)*
- ⇨ *In 2010, approximately 25.1% of the people experiencing homelessness staying in shelters in WV reported mental illness and/or substance use (17)*
- ⇨ *The WV age-adjusted suicide rate in 2010, 14.1 per 100,000 population, was above the national average at 12.1 per 100,000 population (18)*
- ⇨ *In 2011, over 10% of WV's youth reported making a suicide plan in the past year (19)*
- ⇨ *Over 5% of students in grades 9 through 12 reported a suicide attempt within the past 12 months (20)*
- ⇨ *In 2010, almost 30% of domestic violence survivors identified that substance use was a contributing factor to their abuse (21)*

According to the Bureau for Children and Families, there has been an overall reduction in the number of youth out-of-state. The *WV System of Care Youth in Out of Home/State Placement Evaluation Report* indicates the total number of youth in state's custody for a 6 month period through December 2012 was 411 unduplicated youth. In March 2013, a point-in-time review determined that there were approximately 100 empty in-state beds available for youth in State's custody. Upon further discussion with key agency and community-based youth service providers, it was determined that while there do seem to be empty beds, that those beds are not always the correct fit for the youth needing services. A survey was completed and additional stakeholder meetings were conducted to assess the increased capacity of West Virginia to serve youth with mental health and substance use and use disorders, gaps in the service continuum, and to make informed recommendations for the provision of services.

Collaborative Planning & Recommendations

In addition to focus groups, Substance Abuse Taskforce meetings and coordinated statewide adolescent key stakeholder meetings over the past two years, agencies and behavioral health provider organizations met and/or participated in survey administration during the past year. Technical assistance was also provided by Robert Vincent, SAMHSA Public Health Advisor to further discuss improvements necessary for youth service system reform in West Virginia. System–wide transformation is necessary to improve access to care and service navigation for West Virginia adolescents, transitional youth and their families/primary caregivers. The overall system recommendation is to build a solid foundation for sustaining an effective, integrated adolescent and transitional aged youth treatment and recovery support services network. The State will need to explore programmatic infrastructures as they work toward supporting local systems of care that will offer the right services, at the right place and at the right time for West Virginia Youth.

- A Single Point of Entry will improve access and referral to appropriate levels of care
- Every region will provide a full continuum of services for youth and families in-state regardless of payer source
- Consistent Assessment / Diagnostic Tools utilizing electronic records will enhance service delivery and sharing of information between multiple systems

- Training and Technical Assistance for Youth Serving Organizations will improve clinical capacity and ensure quality services
- State and regional collaborative partnerships will increase engagement, improve referral mechanisms and access needed and appropriate community supports
- An increase in the capacity to serve transitioning youth (adolescents and young adults 17-24) will offer a "last best chance" to decrease unemployment, homelessness, and improve behavioral health and health outcomes for this population
- Youth Service Centers will be developed in an inviting location that will decrease stigma and meet the needs of youth and their families through increased hours of operation
- An increase in the number of peer/recovery support groups for youth will assist in maintaining sobriety and community and social connectedness

Building Upon Current Behavioral Health Youth Service System Reform
The West Virginian Behavioral Health Youth Service System will provide individualized strength based services, in a more integrated environment incorporating evidence based practices and effective cross-system collaboration including integrated management of service delivery and cost. This approach is comprised of a spectrum of effective community based services and supports that are organized in a coordinated network that provides meaningful partnerships with families and youth improving the youth's functioning in the home, school and community promoting recovery and resilience.

The system will be coordinated through six (6) Regional Youth Service Centers (R-YSCs) that will implement a cross-system, collaborative approach to youth service delivery, both at a regional and state level, creating a statewide Behavioral Health Youth Service Network. The Substance Abuse Mental Health Service Administration (SAMHSA) Substance Abuse Block Grant is providing funding for regional coordinated programming offered to the communities through an Announcement of Funding Availability (AFA) process. To date, all six (6) regions of the state have been awarded R-YSCs and through technical assistance from BBHHF, grantees have developed strategic plans for service implementation. Additional funding comes from the Youth Suicide Prevention grant (six regional Intervention Specialists to provide for post-discharge follow-up services from inpatient and emergency departments for attempt survivors).

The target population for the R-YSCs are youth ages 12-17, young adults ages 18-24 experiencing mental health and substance use and/or co-occurring substance use and mental health issues and their families/primary caregivers. The YSCs will build regional capacity and provide for more effective early intervention for young adults ages 18-24 presenting with FEP enrolled in the pilot program. The purpose for establishing R-YSCs throughout West Virginia is to:

- Create a centralized information and referral network to serve the target population
- Conduct local needs assessments to identify behavioral health resources for the target population
- Develop, provide for, and coordinate a full continuum of care (prevention, early intervention, treatment and recovery services) for the target population utilizing a data-driven decision model to include the needs assessment information.

The project design for the R-YSC is a single facility or coordinated partnering of multiple facilities to provide a variety of treatment and non-treatment options for youth with mental health disorders and substance use and/or co-occurring disorders. Programming to be offered, as defined by the Substance Abuse and Mental Health Service Administration (SAMHSA) service area definitions, will include: Primary Prevention, Promotion & Wellness, Engagement Service, Outpatient Services, Medication Services, Community Support Services, and Recovery Support Services.

A Referral & Outreach Center (ROC) will be established to provide for a 24-hour call center for individuals seeking behavioral health assistance for West Virginia youth and young adults. Anyone that contacts the R-YSC ROC will be offered education on behavioral health issues and information on community based service options in their region, as well as a facilitated referral to an appropriate level of care based on the individuals need in coordination with regional centers. ROC staff will track and follow-up on all calls made to the R-YSC to ensure quality assurance and successful outcomes. Each of the six (6) R-YSCs will operate in conjunction with one another in order to create the statewide Behavioral Health Youth Services Network. This network will create a **single access point** for all youth behavioral health needs in West Virginia; a resource that addresses the top two identified barriers for families seeking services: access and navigation.

An Engagement (Diagnostic) & Outpatient Clinic will be established as a separate unit within the R-YSCs that will act as a centralized screening, diagnostic, outpatient, intensive outpatient and recovery service center for youth, young adults and their families/primary caregivers. All youth served at the clinic will be screened for the presence of co-occurring substance use and mental health issues; information gained from this screening will be used to develop an appropriate referral to treatment. After initial screening and referral, youth will have access to services that include clinical and specialized assessments, service planning, individual and group therapy, medication services, case management, and recovery support services, all of which will be offered during both traditional and non-traditional business hours. In addition, family/primary caregivers of these youth will have access to consumer/family education, family therapy, and parent/caregiver support. Programming provided for by the R-YSC will be age appropriate, evidence-based, trauma-informed, including assessments and interventions that consider the individual's adverse life experiences within the context of their culture, history, and exposure to traumatic events. Telehealth service options will also be available and utilized by the R-YSC, in addition to the development and implementation of an Electronic Health Record (EHR) system.

Proposed Evidence-Based Program

Currently, an R-YSC has been selected for the pilot program in FY2015, all staff working in the center will participate in training in the EASA model upon competition of the planning phase. Key elements of the pilot program will include **early detection and intervention of psychosis**; team-based care; shared decision making; collaborative treatment planning; wellness, resilience, and recovery orientation; person-centered and trauma-informed care; youth/young adult friendly environment; limited length of treatment; and transition to step-down services. The targeted population for the FEP pilot program, young adults ages 18-24 who require additional assessment and services not currently available in their region will receive a facilitated referral

through the Behavioral Health Youth Service Network to arrange for such services, as available. Upon completion of this service, youth requiring additional programming will be referred back to the region where the youth resides in order to complete treatment and/or recovery programming as recommended. Evidence-based practices that will be utilized for young adults eligible include cognitive behavioral therapy (CBT), trauma-focused cognitive behavioral therapy (TF-CBT), and motivational interviewing and supported employment.

The proposed plan will supplement the planned services and activities of one R-YSCs with dedicated staff for an Intensive Care Coordinator, (1FTE Bachelor level social worker - approximately $50,000 with fringe benefits), Supported Employment and Education Specialist (1FTE Bachelor level social worker - approximately $50,000 with fringe benefits) and a Team Leader (.25 Licensed Clinician - approximately 15,000 with fringe benefits). Cost of treatment will be supported by Medicaid and private insurance when available. The intensive care coordinator (ICC) will provide facilitated community referral and assertive outreach to psychiatric hospitals, emergency rooms crisis service units, higher education and law enforcement. The ICC will maintain a small caseload (serving up to 15 individuals) and coordinate a team-based, youth-centered, integrated treatment modality recovery and individual support; crisis planning and data collection. The Team Leader will provide clinical supervision and program coordination and monitor outcomes and quality assurance. The remaining set aside funds will be utilized for training **early intervention/FEP components of** EASA, Peer and Recovery, and other evidence practices, ongoing monitoring/evaluation of EASA, manuals and other program supplies, flexible funding for individualized supports needed to successfully live in the community. The total budget for the pilot program is $135,788.

Budget

Intensive Care Coordinator (1 FTE Salary and Fringe)		$ 50,000
Supported employment and education specialist (1 FTE salary and fringe)		50,000
Team Leader (.25 FTE salary and fringe)		15,000
Total Salary and Fringe		$ 115,000
Training: EASA, Peer and Recovery, other EBP's	20,788	
Total Budget		$135,788

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Section 6 Participant Directed Care

West Virginia has a number of existing programs for people with disabilities, which include some people with mental health issues, which emphasize self-direction, including the state's three Home and Community-Based Waivers, Money Follows the Person/Take me Home WV, and the Ron Yost, and Lighthouse programs.

West Virginia Bureau of Senior Services Lighthouse program

Lighthouse is designed to assist those seniors who have functional needs in their homes, but whose income or assets disqualify them for Medicaid services. The Lighthouse Program, available in each county, is funded entirely by state monies and provides support in four areas: personal care, mobility, nutrition, and housekeeping.

An individual may receive up to sixty hours of service per month, based on a client assessment and resources available. To participate in the program one must be at least sixty years of age and meet the functional eligibility need. Lighthouse has a sliding scale fee reimbursement in place. See Lighthouse Policy and Procedures Manual for more detailed information.

Medicaid Aged and Disabled (A & D) waiver program

Personal Options is the self-directed service model within the Home and Community Based West Virginia Medicaid Aged and Disabled Waiver (ADW) Program. To participate in Personal Options, an individual must be medically and financially eligible for ADW services.

In Personal Options, the participant is an employer who hires individuals as an employee(s). Participants may advertise for an employee or hire friends or family members as their employee(s). As an employer they will be responsible for verifying the hours worked by employees and the tasks that were completed. A spouse, legal guardian, or legal representative acting as decision-maker on the participant's behalf cannot be hired as an employee. All employees must meet ADW policy requirements such as age, training, background checks, etc.

Participants have an individualized monthly budget based on his/her assessed needs. Budget funds must be used to purchase needed ADW services such as personal assistance/homemaker services, RN assessments, transportation, and case management. Participants can also use part of their monthly budgets to purchase other items and services that promote improved health/safety in the home, or reduce the need for Medicaid services. (Note: Each participant may save and spend a maximum of $1,000 each year for Participant-Directed Goods and Services.) Participants do not handle any money directly. All funds are handled by a Fiscal/Employer Agent.

Personal Options participants have flexibility when determining their employee's/employees' hourly wage and work schedule. The hourly wage cannot exceed the Medicaid reimbursement rate.

Participants in Personal Options have the support of a Resource Consultant and a Fiscal/Employer Agent. Resource Consultants assist participants in developing a service plan and a monthly spending plan to meet their individualized needs. Resource Consultants also assist participants with the responsibilities of self-direction, such as recruiting, hiring, training and managing employees as well as filing all necessary paperwork to become a registered employer with state and federal government authorities. Resource Consultants monitor health and safety of participants and report any incidents or fraudulent activity.

The Fiscal/Employer Agent performs payroll and tax functions on behalf of the participant including processing timesheets, invoices, issuing paychecks to the employees via mail or direct deposit and filing quarterly state and federal taxes and end of year taxes on behalf of participants. Participants do not handle any money directly.

Personal Options participants may transfer to traditional agency services at any time.

Medicaid Intellectual and Developmental Disability Waiver program

If a consumer chooses the Traditional Services and Personal Options Service Delivery Model, he/she can also access the services available through the Traditional Model as well as participant-direct his/her Person-Centered Support Services, Respite Services, Transportation Services, and/or Participant-Directed Goods & Services.

With Traditional Services and Personal Options, the consumer is the employer of record. He/she may appoint someone to be your representative to help him/her with his/her responsibilities. The consumer (and his/her representative if he/she has appointed one) will be responsible for recruiting, hiring, training, and supervising his/her Person-Centered Support and Respite staff. In addition, he/she will set his/her staff's work schedule and their hourly rate of pay.

If he/she chooses this model, he/she will be supported by Public Partnerships, LLC, the contracted Fiscal/Employer Agent. PPL will be responsible for preparing payroll documents and required financial reports for state/local government, and verifying that employees meet qualifications.

He/she will monitor his/her Annual Individualized Waiver Budget, and will not be limited to the caps on direct support hours as indicated in the WV I/DD Waiver manual. Instead, he/she are limited by the amount of money in the part of his/her budget he/she designated for Participant-Directed Services. If he/she chooses this service delivery model, a $320 monthly fee will be assessed; however this will be paid with administrative funds and will therefore not be paid from his/her annual budget.

Medicaid Traumatic Brain Injury Waiver program

Participant-Direction via Personal Options is a person-centered service delivery system where people have greater choice and control over the services they receive and the individuals who provide them. Consumers have the opportunity to exercise employer authority and budget authority: employer Authority includes control over the Participant-Directed Services and the individuals who provide them; budget Authority includes control over how the participant-directed portion of the budget is spent; the consumer will secure, hire, discipline, manage, set work schedule and set wages for the staff he/she chooses to serve him/her. The consumer also chooses services within the Participant-Directed program. The services include: Personal Attendant Services (direct care and transportation) and Participant Directed Goods and Services.

The consumer is able to purchase approved goods or services that address his/her independence and health and safety needs. He/she directs his/her own services with or without the assistance of a legal or non-legal representative. Public Partnerships (PPL) provides financial management and resource consulting for people who choose Personal Options. PPL assists people with all the payroll and tax services, including processing timesheets and invoices and withholding State and Federal Taxes

Ron Yost Personal Assistance Services (RYPAS) program

The RYPAS program is managed by a seven-member consumer-controlled board. Board members are people with disabilities, most of whom have their own personal assistants. The board makes all decisions about the program and the eligibility of applicants for services. Board members are not eligible for services while serving on the Board.

According to the West Virginia Statewide Independent Living Council's website, the RYPAS Program "provides personal care services to assist elderly and / or disabled West Virginia residents in achieving their activities of daily living and to remain living in their homes and communities. Although this is not a Medicaid program, it is modeled after the Medicaid concept of Cash and Counseling. This concept is also referred to as participant direction, self-direction and consumer direction. The idea is that the program participant has control over who provides their care instead of the program administrators. Thereby increasing the satisfaction of the participant and lowering the administrative cost of the program.

Friends, neighbors and even many family members can be hired to provide personal assistance, transportation and even to assist with light home maintenance which the program participant cannot manage on their own. To be eligible for this program, participants must live in West Virginia and have a disability that is expected to continue for a minimum of 12 months. The disability must be significant enough that it requires the individual to receive assistance in order to complete their activities of daily living such as eating, dressing, bathing or basic mobility. In addition, individuals must not be eligible to receive Medicaid services. As part of the application process individuals are required to apply for Medicaid and if rejected they can then be considered for the Ron Yost program. This means the program has effective lower income limits however these change based on the applicant's constituent group (meaning an elderly individual has different criteria than an adult). There are no fixed upper income limits. However funding is provide on a sliding scale, those with larger discrepancies between their expenses and incomes are eligible for more assistance and will receive priority.

This program provides financial assistance in the form of reimbursement checks to participants so that they can hire personal care assistants. Program participants are allocated up to $7.25 / hour to pay a personal assistant. Personal assistants can provide care with the following types of activities and instrumental activities of daily living.

- Basic mobility in and around the home
- Transportation assistance away from the home
- Bathing and personal hygiene
- Dressing
- Meal preparation
- Meal planning and grocery shopping
- Basic housekeeping and laundry

Take Me Home WV

The West Virginia Bureau for Medical Services (BMS) received a Money Follows the Person (MFP) Rebalancing Demonstration Grant in 2011 from the Centers for Medicare and Medicaid Service (CMS)

to assist State Medicaid agencies in enhancing opportunities for people to live and receive long-term care services and support in their own homes and communities.

This initiative, Take Me Home, West Virginia, provides additional services and support to eligible Medicaid members moving from long-term care facilities to their own homes. In addition, the program will explore changes to the State's long-term care system to enhance home and community-based service options for Medicaid members. Individuals in long-term care facilities face a number of challenges in returning to their homes. These challenges include lack of money for rental and utility deposits and basic household items, limited community support and limited assistance in transition plan development.

TMHWV includes Community Transition Services: These are one-time services essential to facilitate the move home. These services may include for example: rental and moving deposits, moving expenses and home accessibility modifications; Take Me Home Goods and Services: These are (self-directed) equipment, services, or supplies not otherwise provided through the Medicaid State Plan that address a need in the Transition Plan, including assistive technology.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

III. BEHAVIORAL HEALTH ASSESSMENT AND PLAN
C. Environmental Factors and Plan

7. Program Integrity

The BBHHF continues to develop and refine the Program Integrity efforts that are applied to all grant and contract awards. Program Integrity (PI) efforts include clinical oversight and evaluation, as referenced in greater detail in several other sections of this application, and financial evaluation, including restrictions on the use of block grant funds. Financial evaluations are performed at several different junctures throughout the grant award and operational processes, and are tailored to each individual award and service provider. All PI efforts are applied to each grant and contract regardless of whether the award is a general revenue funded program or a sub-recipient award of Federal Substance Abuse or Mental Health Block Grant funding.

Oversight of PI Activities

The BBHHF announces all new opportunities for funding through an Announcement of Funding Availability (AFA) process which encourages all interested providers to thoroughly design and propose a service delivery model that is thorough, comprehensive, and readily tested for efficacy and success. The AFA process is overseen by individuals with clinical backgrounds, financial backgrounds, and compliance/monitoring focus to allow for a more comprehensive development of expectations and a more varied focused review of all proposals submitted. The process allows for "scoring" of all proposals to help make objective decisions of what can be a very subjective means of communicating intentions and plans for service delivery. Once awarded, each of the groups continue on with their respective PI activities, which include many different facets of PI review.

Technical Assistance (TA) is offered at all times through the process, beginning with an AFA TA to assist any interested service providers with their development of a sound proposal, and continuing through the life of the award all the way to closing out the award. TA is offered for all facets of the process, including financial documentation, clinical standards, and safety standards.

Specific PI Activities Performed

The BBHHF utilizes many different PI processes including, but not limited to:

Budget reviews at the "line item" level of detail to ensure that service providers are spending awarded funds in a manner consistent with the terms and conditions set forth in the Catalog for Federal Domestic Assistance, the grant or contract language establishing the award, the reporting guidelines established in the award documents, and any other special requirements for financial reporting. All grants and contracts are reimbursed on a reimbursement of costs basis to ensure that funds are only distributed after the budget has been approved and each invoice requesting reimbursement is consistent with the approved budget document.

The Affordable Care Act (ACA) offers additional health coverage options for persons with behavioral health conditions. BBHHF projected block grant expenditures reflect these coverage options. BBHHF understands that the MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the marketplace and Medicaid. Each request for reimbursement is thoroughly reviewed and compared to original expenditure expectations prior to payment adjudication. The majority of services are provided under CFDA and grant Statement of Work expectations and are billed as costs incurred for the provision of services, as opposed to fee for service processing for services provided. Reimbursement of costs ensures that the provider is made whole for any costs incurred that meet the allowability and acceptability established in the award documentation, regardless of whether a fee for service standardized definition of service is available.

Expenditures and requests for reimbursement are monitored for amount expended in the current period and whether that amount is consistent with previous requests for reimbursement, amount expended year to date and whether that amount is on pace for over or under expenditure for the year (or other period of award if less than one full year), and across multiple providers of similar services (when available) to ensure consistent costs among peer agencies. If awarded entities show a trend of under expenditure based upon annual projections, adjustments to the amount of award available to that provider are reduced to allow for redistribution to provider agencies which are showing expenses trending in excess of expectations. These mid period adjustments allow for the ability to redirect funding to the agencies that are demonstrating the greatest need, and supporting the expenditures by showing successful outcomes and performance indicators. Redistribution of funds to agencies demonstrating these values is an excellent way to monitor Program Integrity across multiple agencies.

The BBHHF Monitoring and Compliance sections then use the expenditure analysis and client services utilization data to plan a compliance and quality review of the awarded entities to verify and document the requests for reimbursement, and the client specific demographic and utilization data collected and reported. Compliance for adherence to all applicable Federal, State and other relevant rules is the primary focus of the review, while collection of quality measures creates documentation that can be used by the clinical staff to verify that the program is meeting all expectations of success.

Each client served in a community based or in-patient setting is reported to the BBHHF data system. This allows for litmus tests of recidivism, program outcomes, and performance measures by showing which clients continue to receive services as set forth in their clinical care plans and which clients are being served in either the community or hospital setting. Each encounter is reported and tracked and is included in an episodic data set that retains the flexibility to report the client in a per-episode query or a lifetime services view.

In addition to the monitoring and oversight activities described above, the BBHHF also requires all sub-recipient grantee organizations to submit an annual independent audit of financial statements and an approved indirect rate, if indirect costs are requested in the budget

submitted by the organization. The documentation prepared by and sent by the independent CPA allows a basis for financial review of the BBHHF fiscal unit and the BBHHF Compliance and Quality review unit.

The state reimburses services provided at the Medicaid rate to any provider rendering services to a non-Medicaid eligible individual using state general revenue funding. Block grant funds are used to render services that are not Medicaid eligible and for services that are not client specific but broad based, such as prevention services.

Environmental Factors and Plan

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

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[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

The State of WV has no recognized tribes.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 9 Prevention of Substance Abuse

1. **Please indicate if the state has an active SEOW. If so, please describe: • The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors)** The Bureau for Behavior Health and Health Facilities continues to be the designated host agency for the State Epidemiological Outcomes Workgroup (SEOW) project. The West Virginia SEOW was assembled to lead the statewide systematic process to gather, review, analyze, translate and disseminate information about substance use and abuse and mental health in West Virginia. State, Regional and County profiles are compiled for web-based dissemination and updated yearly. Data reported in the West Virginia Behavioral Health Epidemiological Profile (State-level) is compiled by partnering WVSEOW agencies, including: CAMC's Health Education & Research Institute, First Choice Services, Inc., the Governor's Highway Safety Program, West Virginia Bureau for Children and Families, West Virginia Bureau for Medical Services, West Virginia Bureau for Public Health-Office of Epidemiology and Prevention Services, West Virginia Bureau for Public Health-Health Statistics Center, West Virginia Bureau for Public Health-Office of Maternal, Child and Family Health, Division of Research, Evaluation and Planning, West Virginia Coalition Against Domestic Violence, West Virginia Coalition to End Homelessness, West Virginia Department of Education Office of Healthy Schools, West Virginia Department of Education Office of Research, West Virginia Division of Corrections, West Virginia Division of Justice and Community Services-Office of Research and Strategic Planning and Justice Center for Evidence Based Practice, West Virginia Statistical Analysis Center, West Virginia Health Care Authority, West Virginia Higher Education Policy Commission, West Virginia National Guard Prevention, Treatment and Outreach, West Virginia Poison Center Robert C. Byrd Health Sciences Center, Charleston Division, West Virginia State Police, the West Virginia Supreme Court of Appeals, West Virginia Rural Health Association, West Virginia Bureau of Prisons, WV Controlled Substances Monitoring Program-WV Board of Pharmacy and the WV Division of Motor Vehicles. The BBHHF has expanded research and planning efforts to further enhance the ability and capacity to garner, evaluate and expand behavioral health profiles system wide. The West Virginia Poison Control Center leads the Early Warning Work Group that identifies trends in substance abuse and provides alerts to educators, behavioral health providers and law enforcement. Regional Data and Planning Teams (DPT's) support the collection and translation of data at the community level and are facilitated by regional prevention grantees, with a required membership that includes: Law Enforcement, Education, Health, Mental Health and Youth. To further validate community based discussions on "new drugs and methods of use" a new system was put into place with all prevention grantees. During each educational presentation on substance use a section was developed to facilitate participant response and all information is gathered and forwarded to the State Prevention Coordinator and WVSEOW Epidemiologist for review and verification in coordination with the Early Warning Work Group. The WV Behavioral Health State and County Profiles can be viewed electronically that include all indicators: http://www.dhhr.wv.gov/bhhf/resources/Pages/DADA_Resources.aspx

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds. Prevention allocations are determined at a minimum of 20% of total block grant funds. Each region receives formula based funding based on population. The strategic prevention framework model is utilized to determine need at the local level as well as county profiles developed by the Bureau for Behavioral Health and Health Facilities in coordination with the WVSEOW.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce? All prevention grantees and sub-grantees have a professional development plan that focuses on the knowledge, skills and abilities needed for the position that is also in alignment with credentialing. West Virginia encourages IC & RC certification and is in the processes of developing a community based support credential for para-professionals or those entering the field. The State Prevention Coordinator, NPN, and other lead prevention professionals provides training and technical assistance and works to build the capacity of the prevention network and communities. Grantees are also trained evidence based programs determined by the needs of the community that reflect the risk factors and population of need. In addition to the personalized professional development plan, all grantees must participate in group learning opportunities offered during quarterly meetings and scheduled program trainings that are required through their provider contracts, including:

- Prevention Specialist Training
- Suicide Prevention Training
- Family Centered Practice
- Coalition Development
- Evidence Based Program Identification and Selection
- Professionalism
- Cultural Competency (LGBTQ, SMVF Specific)
- True Colors Personality Assessment Group Training
- FASD and Drug Exposed Babies
- Physician Engagement
- Social Marketing
- TIPS Training
- Forum Planning and Implementation
- Stress Management
- Drug- Free Workplace

- Synar Merchant Education, Programming and Protocols
- Prevention Education Trainings Specific to Substances (Prescription Drugs, Alcohol, etc.)

4. Please describe if the state has:

a. A statewide licensing or certification program for the substance abuse prevention workforce: yes, community support certification, which is a step below prevention specialist through IC & RC

b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce-All grantees have the same requirements within their statements of work

c. A formal mechanism to assess community readiness to implement prevention strategies-upon the initiation of a new coalition readiness assessments are completed and community capacity determined and training and technical assistance provided based on need.

5. How does the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?

Both qualitative and quantitative data is utilized in the planning process. State, Regional, and County Profiles were developed and disseminated to the Governor's Advisory Council and at Governor's Regional Task Force Meetings in every region of the State. Each Regional Prevention Organization facilitates Data and Planning Teams that work in coordination with the WV State Epidemiological Outcomes Workgroup to support the collection and use of data at the community level. Town Hall Meetings are also conducted at county and regional levels to determine local need. Regional Task Forces prioritize regional needs and the Governor's Advisory Council makes recommendations to the Governor. Input from listening tours, review of prior planning documents, and prevailing evidence-based philosophy and practice contribute to the selection of programs and practices.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG. Yes, the WV State Substance Abuse Strategic Plan is in the process of being updated currently. It was developed and disseminated statewide through the Governor's Regional Task Forces after a formal needs assessment process.

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy. Those decisions are made at the state level by the SSA and the Prevention Team. The Governor's Advisory Council has some decision-making authority if priorities change based on data presented.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

Prevention grantees report in the 6 CSAP Strategy areas. 100% of grantees use the Strategic Prevention Framework as the preferred planning model and develop county level plans for each area. There are coalition leads in each of WV's 55 counties. Each region is somewhat different and based on the readiness of the particular community the level of coalition development training as well as program selection is different. 100% of all counties participate in Drug Take Back Programs and Safe Storage Initiatives. Percentages of strategies are included in block grant fiscal tables—but to note, environmental strategies continue to increase as universal practices. Additional evidence based programs that are currently being implemented based on the identified community needs and supports in school based settings include:

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means? A minimum of 20% set a side is allocated to 6 Regional Prevention Lead organizations

10. What process data (i.e. numbers served, participant satisfaction, attendance) does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system? All Block Grant required data as well as training satisfaction surveys with attendance is included because most training participants receive continuing education.

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system? This is collected through NSDUH as well as the WV School Climate Survey. The State will collect SA Prevalence for Prescription for youth and transitioning youth, over dose rates and binge drinking.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

In an attachment to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

III. BEHAVIORAL HEALTH ASSESSMENT AND PLAN
C. Environmental Factors and Plan

10. Quality Improvement Plan

Quality improvement is the use of a deliberate and continuous effort to achieve measurable improvements in the identified indicators of quality of care. This includes determining which measures are needed to monitor quality, collecting the information needed, and using the findings to make changes to improve quality.

The BBHHF is in the middle stages of development and adoption of a full Continuous Quality Improvement/Total Quality Management (CQI/TQM) plan and is in the early stages of implementation. These CQI processes will identify and track critical outcomes and performance measures, based on valid and reliable data consistent with the NBHQF. Several of the concepts of CQI have been built into Bureau activities and functions of payers in the past, and the adoption of a more formal plan will help to solidify efforts that are already in process. Several of the State's publicly funded behavioral health providers have developed their own CQI approaches and adopted recognized CQI/TQM plans for their respective operations. These endeavors provide a foundation for continued development and implementation of the statewide CQI/TQM Plan.

BBHHF Activities Related to CQI

The Bureau is in the development phase of a systemic formalized process for ensuring that CQI is stakeholder driven. The BBHHF currently has several mechanisms in place for soliciting stakeholder input for the development of quality improvement indicators. Stakeholders include consumers and their families, administration and staff of the BBHHF, the BBHHF Office of Consumer Affairs and Community Outreach, service providers, advocacy organizations, the Mental Health Planning Council, the West Virginia State Epidemiological and Outcomes Workgroup (WVSEOW), and other partners.

The BBHHF has collaborated with providers to develop standardized definitions and standardized Statements of Work for all sub-recipient and general revenue funded grant agreements for behavioral health prevention, early intervention, treatment, and recovery services. This includes outcome performance, peer review, and cultural competence compliance measures. The development of these standardized documents provides for consistent assessment and evaluation of programs and processes across the State and contributes to the development of a CQI Plan. Guiding principles include the beliefs that behavioral health is an essential part of health, prevention works, treatment is effective, and people can and do recover from mental and substance use disorders.

The BBHHF Data and Technology Team capture behavioral health episodic utilization data from the State's thirteen comprehensive service providers in coordination with APS Healthcare, the State Medicaid Authority's Utilization Management contractor. Providers submit information to APS Healthcare regardless of payer source for all services provided. In addition to capturing

client services data and demographic data for all consumers served, APS Healthcare uses clinical information submitted for Medicaid-eligible consumers to provide prior authorization approvals for requested services. The organization uses aggregate data and individual agency data to develop technical assistance for providers to improve outcomes and for quality improvement.

The BBHHF data reporting system collects client data containing demographic data, services provided, and information for federal and state reporting, such as Treatment Episode Data Set (TEDS), Block Grant Reports and URS tables.

These report both duplicated and non-duplicated counts of persons in a variety of demographic groups, such as age, gender, race, disability group (MH, SA, IDD), employment status, housing status, funding (Medicare, Medicaid, or private pay), service locations (i.e., in-state psychiatric hospitals, community setting, group homes), legal and drug involvement.

These data are also used to report back to providers the number of records sent each day, the number of persons served this year, and quality issues, such as missing or unexpected changes in data (date of birth). Logic validations are also used (i.e. Age<14 and divorced, married, widowed).

The BBHHF Data and Technology Team validate the data submitted to APS Healthcare and submit validation reports to individual providers to assure the data are accurate. The Single State Authority for substance abuse prevention and treatment (SSA) and the Mental Health Authority (MHA) may query these data to identify trends and measure performance of individual providers. The SSA is able to use these data to identify the use of evidence based practices and types of prevention activities by provider and in the aggregate.

Non-comprehensive providers currently do not provide data to the Bureau using the APS system. However, aggregate level demographic data elements as well as narratives regarding services provided are submitted via an alternate collection platform. In an effort to streamline this data collection process, BBHHF is considering developing an application that would allow these providers to submit client level data in a format similar to those collected via the APS method. This would allow for a more comprehensive picture of the behavioral health system in WV, and could also be used for Quality Improvement initiatives.

Additionally, a vendor developed web portal collects and reports data provided by substance abuse prevention sub-recipient grantees. The SSA is able to use these data to identify the use of evidence based practices and types of prevention activities by provider and in the aggregate.

Provider Activity Related to CQI

At least six of the State's 13 Comprehensive Community Behavioral Health Centers have utilized NIATx principles for quality improvement. These centers used recommendations of stakeholders in the development of the NIATx study and changes in service delivery. The NIATx rapid cycle process improvement model identifies issues related to decreasing wait time for

services, decreasing no show rates for appointments, increasing admissions into services, and increasing continuation in treatment.

In addition to the NIATx processes, one Comprehensive Community Behavioral Health Center has a compliance council that meets monthly. The council completes monthly safety inspections for all group home facilities, analyzes and trends chart reviews and clinical supervisions, reviews trend data for incident reports, and reviews general training and documentation compliance issues. The Center utilizes information from its compliance council for continuous quality improvement.

Some of the substance abuse treatment services operated by the State's largest publicly funded Comprehensive Community Behavioral Health Center have been accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), which includes a CQI component.

The BBHHF proposes to track components of these provider activities related to CQI in order to continuously measure the effectiveness of services and supports, and ensure that they continue to reflect this evidence of effectiveness. These data will be compiled into quarterly reports.

Additionally, to assure that the BBHHF is able to track programmatic improvements at the stakeholder level, the BBHHF proposes to develop surveys for the general population, individuals in treatment and recovery, and their families. Results of these surveys will be compiled into reports to be used in the CQI process.

Response to Critical Incidents, Complaints, and Grievances

Responsibility for overseeing consumer health and safety and responding to critical incidents in West Virginia rests with the Office of Health Facility Licensure and Certification (OHFLAC), which was moved into the Department of Health and Human Resources' Office of the Inspector General. In this capacity, OHFLAC has a designated Behavioral Health Program which enforces the agency's Behavioral Health Center's Licensure Rule, Title 64 Code of State Rules Series 11 (§64CSR11). The scope of this rule includes licensed behavioral health providers (not including hospitals, long-term care facilities or private practitioners) serving people with intellectual disabilities, mental illnesses, and addictions.

§64 CSR 11, Section 7.7 requires licensed behavioral health centers to "maintain a system for critical incident reporting and demonstrate that it uses the system to improve treatment planning and services" and agency staff to "immediately notify a supervisor of any critical incident and clear other consumers from the area."

§64 CSR 11, Section 8.2 describes the broad requirements licensed behavioral health centers must use when addressing alleged consumer rights' violations and responding to people's complaints. Section 8.2.a. establishes the right of consumers to file complaints and requires that a "supervisor shall report to the [agency] administrator within twenty-four (24) hours regarding all violations, or suspected violations, of a consumer's rights, except in the case of physical abuse for which immediate notification shall be made." Section 8.2.b. requires the

agency to “have evidence that all violations, or suspected violations, of a consumer’s rights are thoroughly investigated within a reasonable time period” and, subsequently, that the agency administrator “provide a written report to the [required] human rights committee of his findings and of the actions taken to prevent further occurrences.” Finally, Section 8.2.d. gives each consumer the right to “appeal to the governing body of the Center, the State licensure body, the [State Protection and Advocacy Agency] or other appropriate resource” if the “administrator’s findings and actions on behalf of a consumer regarding a violation of the consumer's rights is unfavorable, insufficient or not forthcoming within a reasonable time.” Each of the licensed behavioral health centers has, in turn, developed their own grievance policies and procedures to comply with the above requirements.

The BBHHF has established its own ancillary process to address informal complaints from consumers and families and other interested parties. This process begins with assistance from staff working in the Office of Consumer Affairs and Community Outreach (CACO), with support as needed from BBHHF’s clinical divisions and/or referral to an independent advocacy group, such as the State Protection and Advocacy Agency and Legal Aid of West Virginia’s grant funded Behavioral Health Advocacy project. In addition, some provider-developed grievance processes include a final appeal option to BBHHF, and CACO has established a process to review and respond to these formal appeals.

Each request for assistance is logged and tracked in the form of quarterly reports for the purpose of trend reporting and analysis with BBHHF’s Clinical Divisions and Monitoring Unit. Follow up calls are also made by CACO staff to assure that the more urgent requests have been appropriately and subsequently addressed by the applicable grant funded community providers. This information is also tracked by CACO and used for the purpose of reporting and analysis.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate, so that these services and programs can be supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

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75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

IV: Narrative Plan

11. Trauma

Although West Virginia does not currently have formal policies in place for standardized screening and connecting individuals with trauma histories, there is significant amount of best practices across the state to increase screening and referral to treatment for individuals who may have or potentially have experienced trauma. In addition, the Bureau for Behavioral Health and Health Facilities (BBHHF) requires all federal and state funded grantees to be trained in trauma-informed care. This requirement is outlined in each of its grantee's statements of work.

A best practice guideline report was completed in early 2013 by the Service Delivery and Development Work Group/Trauma Best Practices, established by the Commission to Study Residential Placement of Children. As a result of the workgroup's research and recommendations and the commitment of public and private systems/agencies, significant progress has been made to improve screening and assessing trauma in children and adolescents. Highlights include:

- Trauma has been incorporated into the West Virginia Child and Adolescent Needs and Strengths (WVCANS) Comprehensive Multisystem Assessment;
- The Comprehensive Assessment and Planning System (CAPS) Project for children and adolescents receiving child welfare services has been revised to trigger a specific trauma assessment;
- Strong motivation across public and private systems/agencies to improve trauma screening and treatment and trauma informed care;
- Significant expertise exists across the state in trauma treatment
- Significant training has been conducted to increase understanding, recognition and best practices for addressing trauma impacting both the children and adult service delivery system. We are planning periodic clinical supervision/case consultation sessions through the Regional Youth Service Centers this fiscal year to promote peer support and sustainability of skills.
- The overarching theme of the 2015 Integrated Behavioral Health Conference is "Trauma-Informed Systems of Care," featuring research and practice experts from across the country.

The types of evidence based assessments to address trauma history and/or trauma specific symptoms available across the life span include:

Children and Adolescents:

- Trauma Symptom Checklist for Children (TSCC)
- Trauma Symptom Checklist for Young Children (TSCYC)
- Child Sexual Behavior Inventory (CSBI)
- UCLA Post Traumatic Stress Disorder (PTSD) Index for DSM-IV
- Chadwick Center Trauma History Checklist
- Achenback Child Behavior Checklist
- West Virginia Trauma-Informed Child and Adolescent Needs Strengths (WVCANS) Assessment

Adults:

- Trauma Assessment for Adults (TAA)
- PTSD Checklist for Adults (PCL-A)
- Evaluation of Lifetime Stressors (ELS)
- Trauma History Screen (THS)
- UCLA Adult Post Traumatic Stress Disorder (PTSD) Scale
- Traumatic Events Screening Inventory (TESI)
- Trauma History Questionnaire (THQ).

Research was conducted to identify evidence based as well as best/promising clinical practices that can be implemented to mitigate traumatic stress reactions. The trauma specific interventions available include:

- Sanctuary Model
- Seeking Safety
- Trauma Focused Cognitive Behavior Therapy (TF-CBT)
- Parent Child Interaction Therapy (PCIT)
- Multi-Systemic Therapy
- Dialectical Behavioral Therapy
- Structured Psychotherapy for Adolescents
- Pharmacotherapy
- Alternatives for Families-CBT (AF-CBT).

There has been a significant amount of training across the state to increase capacity of providers to deliver trauma-specific interventions. The BBHHF is providing its second Comprehensive Behavioral Health Conference September 22 – 24, 2015. A multitude of key notes, workshops and skill-building sessions are being offered on trauma treatment and cultural competency. A consultant from the San Diego Chadwick Center for Children will return by popular demand to provide a keynote address and two workshops, one of which is specifically addressing one of the BBHHF's priority populations: Lesbian, Bi-Sexual, Gay,

Transgender and Questioning (LBGTQ) youth. Several skill-building sessions are devoted to an emerging priority population for WV: individuals with co-existing developmental disabilities and mental health challenges. The conference features three nationally recognized experts in recognizing and treating trauma experienced by individuals with autism and other developmental disabilities. Addressing trauma across the life span is a critical priority of the BBHHF. The BBHHF initiated a partnership with the National Center for Trauma Informed Care (NCTIC) in July 2013 (See Section IV. Narrative Plan, U. Technical Assistance Needs for progress and plans) and are committed to increasing training opportunities and technical assistance to increase trauma specific interventions and as well as trauma informed care. With the invaluable partnership and technical assistance of the NCTIC, the BBHHF is collaborating with the Bureaus of Child and Family, Public Health, and Medical Services, the West Virginia Department of Education, the Divisions of Juvenile/Criminal Justice and community providers to develop policies and standards of care that guide not only trauma treatment but trauma informed care utilizing a public health approach for individuals across the life span.

Environmental Factors and Plan

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment. Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance use disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.[80] [81] Rottman described the therapeutic value of problem-solving courts: "Specialized courts provide a forum in which the adversarial process can be relaxed and problem-solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs." Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

Please consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals?
4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs, U.S. Department of Justice, Renee L. Bender, 2001.

[82] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 12 Criminal and Juvenile Justice

1. **Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?** Individuals currently cannot receive WV Medicaid while incarcerated but every effort is made to being initiate the process prior to release.

2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders? The LSCMI is conducted upon entry, during changes in the disposition of the individual and prior to release. A mental health questionnaire is completed as well for all individuals entering facilities. If the screen is positive then the individual is immediately referred to a **counselor for further testing and treatment.**

3. Do the SMHA and SSA coordinate with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities and the reentry process for those individuals? The Bureau for Behavioral Health and Health facilities helped develop the Justice Reinvestment Plan for implementing community based treatment services for individuals re-entering WV communities. This partnership has provided opportunities for cross-agency collaboration and sharing expertise of the population and best practices in criminogenic behaviors behavioral health treatment and recovery.

4. Are cross-trainings provided for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? Yes, a series of trainings are required for all JRI grantees providing behavioral health services to individuals who are/have been involved with the criminal justice system.

Environmental Factors and Plan

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

13. State Parity Efforts

Given that the Mental Health Parity and Addiction Equity Act, and the final parity rule for private insurers which took effect July 1, 2014, does apply to plans offered through the exchanges, it is extremely important that BBHHF continue to take an active role in educating its providers, consumers and families and the general public about both mental health parity, health care expansion and partner with other agencies and nonprofits to assist with education on and enrollment in both state Medicaid Expansion activities and use of the Exchange/Marketplace Call Center, Website and face to face Navigators.

NAMI's recently released (April 2015) report on Parity, A Long Road Ahead – Achieving True Parity in mental health and Substance Abuse Care, concluded that "while progress is being made in law, we have a long way to go to achieve true parity in mental health and substance use care" and noted systemic issues such as finding appropriate service providers, denials of prior authorization, barriers to accessing prescribed medications and, perhaps most significantly for BBHHF, "Serious deficiencies in access to information necessary to enable consumers to make informed decisions about the health plans that are best for them in ACA networks."

Furthermore, as noted previously in Section 1, BBHHF has actively participated in planning meetings held between the Bureau for Medical Services, APS Healthcare, the four regional Managed Care Organizations (MCOs) and the West Virginia Behavioral Health Provider's Association (WVBHPA - the trade organization for the 13 CBHCs and other providers) to discuss development of the MCO behavioral health provider organization networks, how care will be coordinated within the managed care context, the appeals and prior authorization processes and how behavioral health services will be rolled into managed care beginning July 1, 2015. With this in mind, and the May 26, 2015 release of the CMS released proposed rule on Medicaid and Children's Health Insurance Program (CHIP) managed care, BBHHF has been proactively monitoring the status and implications of the rule and the related ramifications for consumers with behavioral health issues being pulled into Managed Care for the first time.

The BBHHF has been participating in the Health Insurance Marketplace calls targeted to West Virginia stakeholders and designated staff will use in person education and well as its website and network emails to become a Champion for Coverage by promoting consumer outreach material made available by its federal partners on both the marketplace@cms.gov website and national nonprofit advocacy organizations on http://parityispersonal.org/, including website widgets, network e-mails, posters and fact sheets, and educational conference calls.

Staff will also continue to help to facilitate in person training for groups like the West Virginia Behavioral Health Provider's Association, Behavioral Health Planning Council, the Governor's Advisory Council on Substance Abuse, peer recovery providers and the BRSS TACS Team. For example, the Office of Consumer Affairs and Community Outreach has hired a former employee of the West Virginia Office the Insurance Commissioner who is extremely knowledgeable in the application process and have other staff who have received training from the West Virginians for Affordable Health Care and use this training to communicate and work with stakeholders, including behavioral health providers, advocates, people in recovery and family members, and to conduct outreach to people with mental health and substance use issues at peer support centers, FQHCs and CBHCs and hospital settings.

BBHHF will also use it's website to create an educational page on Parity, inclusive of educational materials, links and other related resources, such as the toll-free number and website link for the Consumer Service Division of the WV Office of the Insurance Commissioner 888-879-9842 and http://www.wvinsurance.gov/ConsumerServices/ConsumerServices.aspx

Because the Office of Consumer Affairs and Community Outreach conducts education and outreach as part of its ongoing responsibilities, funds have not needed to be set aside thus far in order to educate and raise awareness specifically about parity.

Environmental Factors and Plan

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 14 Medication Assisted Treatment

West Virginia has nine (9) opioid treatment facilities located throughout the six (6) regions of the state. According to SAMSHA, 187practitioners in WV have the DEA waiver to provide medication-assisted treatment (MAT). Of these practitioners, WV's Bureau for Medical Services has 145 enrolled to provide non-methadone, medication assisted treatment to WV Medicaid participants.

1. ***How will/can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?***
    - Currently the WVBBHHF has language within its provider contracts which require the provision of and/or coordination of care for individuals seeking and/or utilizing medication assisted treatment services. These services include: Crisis Stabilization, Residential Treatment, Treatment Provider Recovery Facilities and Peer programming/services. Contracted providers report monthly outcome data of those involved with MAT services. The WVBBHHF also conduct compliance reviews and provides technical assistance to ensure its providers are meeting these requirements. The Bureau will continue to integrate MAT into all future contractual agreements with its providers for substance use and/or co-occurring SA/MH services.
    - Quarterly, statewide substance use treatment provider meetings are held with the 13 CBHCs; MAT and its utilization, barriers, trends, etc. is a standing topic of discussion during those meetings. This is also a venue for the Bureau to communicate its mission for MAT utilization across WV, as well as educate and troubleshoot provider issues/concerns.
    - WV's Substance Abuse Regional Taskforce, representing the six (6) statewide regions, meeting quarterly to discuss strategies for addressing substance use issues, as well as educating themselves and their communities on this information. Many taskforce presentations have focused specifically on MAT in an effort to educate and raise awareness.
    - WV's Integrated Behavioral Health Conference has and will continue to provide sessions on medication assisted treatment and offer an abundance of continuing education, workforce develop and networking opportunities for substance use providers and community stakeholders. The Bureau also supports the Appalachian Addictions Physicians Conference, which focuses exclusively on substance use treatment and has a major emphasis on understanding and improving the utilization of MAT. This is also a very strong workforce development and networking opportunity for WV's physicians, most of which do not specialize in addiction treatment.
2. ***What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?***
    - WV's Comprehensive Substance Abuse Strategic Action Plan SA Strategic Action Plan has been in place since 2011. Medication assisted treatment was central to the development of the plans goals, objectives and strategies. Pregnant women is a specialty population targeted for service delivery within that plan and many projects have been developed

throughout the state that focus specifically on working with this vulnerable group. In 2015 the WVBBHHF and GACSA will begin working to create/update WV's strategic plan. This will be done in coordination with the six (6) regional Substance Abuse Regional Taskforces, substance use treatment providers and other stakeholders to ensure the plan is representative of the State's needs within multiple systems and at multiple levels.

- Specific pregnant women programming/services with a focus on utilization and/or care coordination of MAT services include: 5 Mom's and Babies projects, Dr. David Chaffin's MARC Clinic, Pregnant and Postpartum Women's Residential Treatment, Treatment Provider Recovery Facilities, Peer Center and Peer Coaching services. WV will also expand its Pregnant and Postpartum Women's Residential pilot (Turning Pointe) to develop infrastructure in the five (5) remaining regions of the state.
- The WVBBHHF has also developed three (3) detoxification crisis stabilization sites throughout the state. These programs were required to provide for MAT services to interested, appropriate individuals admitted for substance use disorder detoxification. WV Medicaid reimburses for the crisis stabilization services which includes detox and non-methadone MAT. The Bureau will continue to develop its detoxification crisis stabilization infrastructure in underserved areas of the state.

3. ***What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?***

    - WV Bureau for Medical Services reimburses for non-methadone MAT. WV has an APO (APS Healthcare) that is responsible for monitoring appropriate utilization of all WV Medicaid services as defined by the WVBMS Provider Manuals. WVBBHHF provides funding to 13 CBHCs for the provision of WV Medicaid services to un- or under- insured individuals. These 'indigent care' services are also regulated by the APO in accordance with the WVBMS Provider Manuals. WVBBHHF participates in all WVBMS Provider Manual revisions; these occur every two years for all behavioral health services (including non-methadone MAT). WVBBHHF, WVBMS and the APO meet quarterly to discuss and resolve provider and/or service issues. These entities will also provide technical assistance to WV Medicaid providers as needed to promote quality assurance and appropriateness.
    - Currently the WVBBHHF has language within its provider contracts which require the provision of and/or coordination of care for individuals seeking and/or utilizing medication assisted treatment services. These services include: Crisis Stabilization, Residential Treatment, Treatment Provider Recovery Facilities and Peer programming/services. Contracted providers report monthly outcome data of those involved with MAT services. The WVBBHHF also conduct compliance reviews and provides technical assistance to ensure its providers are meeting these requirements. The Bureau will continue to integrate MAT

into all future contractual agreements with its providers for substance use and/or co-occurring SA/MH services.

- Quarterly, statewide substance use treatment provider meetings are held with the 13 CBHCs; MAT and its utilization, barriers, trends, etc. is a standing topic of discussion during those meetings. This is also a venue for the Bureau to communicate its mission for MAT utilization across WV, as well as educate and troubleshoot provider issues/concerns.

WV will continue the efforts described above in order to strengthen a positive statewide perception of medication assisted treatment among the substance use treatment providers and the community at large. WV will also pursue partnerships and opportunities to educate, raise awareness and increase appropriate utilization of evidence-based MAT services.

Environmental Factors and Plan

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 15 Crisis Services

WV's behavioral health crisis response system is developed with the capacity to prevent, recognize, respond, deescalate and follow-up from crises across a continuum. This crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. Some of this basic infrastructure includes providing for crisis planning, early stages of support and respite, crisis stabilization and intervention, as well as post-crisis follow-up and support for the individual and their families/primary supports. West Virginia's thirteen (13) comprehensive behavioral health centers (CBHCs) are mandated to provide crisis services in all 55 counties and act as the 'provider of last resort' for the system. Additionally, many public and private organizations also provide crisis services to further enhance WV's crisis system. The array of services and supports being used to address crisis response in West Virginia include the following:

Crisis Prevention and Early Intervention:

- **Wellness Recovery Action Plan (WRAP) Crisis Planning**; Peer Support Services/Programming, Peer Centers, Peer Coaches, Recovery Facilities, MH/IDD Group Homes, ACT
- **Psychiatric Advance Directives**; ACT, MH/IDD Group Homes, Crisis Stabilization
- **Family Engagement**; Peer Support Services/Programming, Peer Centers, Peer Coaches, CES, RYSC
- **Safety Planning**; Peer Support Services/Programming, Peer Centers, Recovery Facilities, MH/IDD Group Homes, ACT, CBHC Crisis Team, Positive Behavior Support assessment and crisis prevention plans
- Resource Coordinators with IDD Crisis Response Programs provide information/support/consultation for families to reduce need for crisis placements
- Peer Operated Warm Lines (None but will begin with new statewide behavioral health call line)
- Peer-Run Crisis Respite Program (None)
- **Suicide Prevention**; Prevent Suicide WV, CBHC Crisis Team

Crisis Intervention/Stabilization:

- **Assessment/Triage (Living Room Model)**; Peer Centers
- **Open Dialogue;** CBHC Crisis Team, Peer Support Services/Programming, Peer Centers, Peer Coaches, Recovery Facilities, MH/IDD Group Homes, ACT, CES
- **Crisis Residential/Respite**; 13 CBHC, 13 CSU sites, 4 IDD crisis response programs for adults/2 IDD crisis response programs for children
- **Crisis Intervention Team/Law Enforcement**; 13 CBHC Crisis Teams
- **Mobile Crisis Outreach**; CES, on-site Positive Behavior Support consultation
- **Collaboration with Hospital Emergency Departments and Urgent Care System**; CES, CBHC Crisis Team

Post Crisis Intervention/Support:

- **WRAP Post-Crisis**; Peer Support Services/Programming, Peer Centers, Peer Coaches, Recovery Facilities, MH/IDD Group Homes, ACT
- **Peer Support/Peer Bridger**; Peer Support Services/Programming, Peer Centers, Peer Coaches
- **Follow-up Outreach and Support**; CES, Peer Support Services/Programming, Peer Centers, Peer Coaches, Recovery Facilities, MH/IDD Group Homes, ACT
- Family-to-Family Engagement Legal Aid's Family Advocacy, Support and Training (FAST) program is a Block Grant funded statewide parent and youth network that engages families in the planning, management and evaluation of their child's mental health treatment and service needs and Mountain State Parents Child and Adolescent Network (MSP-CAN) is a State Family Network grantee which works with families in DHHR/BCF Region 1
- **Connection to care coordination and follow-up clinical care for individuals in crisis**; CES, 13 CMHCs
- Follow-up crisis engagement with families and involved community members: Resource Coordinators with IDD Crisis Response Programs provide post discharge information/support/consultation for families and other providers to promote stability in the community.

Environmental Factors and Plan

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Recovery is based on the involvement of consumers/peers and their family members. States should work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that SMHAs and SSAs can undertake to engage these individuals and families. In the space below, states should describe their efforts to engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
4. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 16. Recovery

Please answer yes or no to the following questions:

1. **Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?**

   Yes, the State is using SAMHSA's working definition of recovery.

2. **Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?**

   Yes, the BBHHF has an office of Consumer Affairs and Community Outreach that supports hiring of individuals with lived experience, including its director and several key staff.

3. **Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?**

   Yes, in all State and Federal planning.

4. **Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible**

   Yes, including but not limited to expanding access to both traditional and non-traditional services and supports, such as peer supports, peer centers, Wellness Recovery Action Planning, Recovery Coaches, psychiatric advance directives and other and decision support tools, Whole Health Action Management, and through the implantation of Common Ground.

5. **Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?**

   Yes, and BBHHF is coordinating activities with the VA, National Guard and other groups on this initiative. This includes BBHHF's current trauma informed care initiative.

6. **Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?**

   Yes. BBHHF provides both funding and on-going training through the Office of Consumer Affairs and each of the program divisions.

7. **Does the state have an accreditation program, certification program, or standards for peer-run services?**

Yes, a certification program for peer and community support services is in the process of being finalized. Also, all peer centers and peer run services are asked to adhered to COSP guidelines as identified in the Consumer Operated Services EBP kit.

8. **Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.**

   West Virginia was awarded a Bringing Recovery Supports to Scale Technical Assistance Center (BRSS TACS) Policy Academy grant and is participating in the technical assistance provided and has submitted a draft State Action Plan and Logic Model. The State is using its Policy Academy and grant funds to help prepare people with mental health and substance use issues improve their access to integrated health care by services by taking the following steps: Developing certification guidelines for Peer Support Specialists and Recovery Coaches; Creating strategies for expanding funding and/or realigning current resources to support Peer Support Specialists, Recovery Coaches, and wellness and recovery centers; Training persons in recovery (peers) to facilitate Wellness Recovery Action Planning and advise behavioral health center staff on evidence based practices in deploying recovery supports; and, Training and use Peer Health Integrators (PHIs) to prepare peers for expanded access to insurance coverage brought about by the ACA/healthcare reform.

Involvement of Individuals and Families

1. **How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?**

   Listening tours statewide, regular scheduled Governor’s Task Force Meetings with communities, provider surveys, and the pending establishment of the Commissioner’s Consumer Advisory Board. The WV Behavioral Health Planning Council also facilitates planning, delivery, and evaluation of all behavioral health services by individuals in recovery and family members represented on the council.

2. **Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?**

   Yes, the West Virginia Leadership Academy, the annual Families Conference, and the Behavioral Health Advisory Council. West Virginia Advocates, in partnership with BBHHF, has also recently launched quarterly peer center meetings where peer center representatives, consumers, and

family members work collaboratively to improve peer services across West Virginia. BBHHF program and CACO staff actively participate in this effort.

3. **How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?**

   The West Virginia Leadership Academy, the annual Families Conference, and the Behavioral Health Advisory Council all promote these approaches and the BRSS TACS Team will be making additional recommendations on enhancing an ongoing feedback loop between BBHHF, its grant-funded providers and consumers and families. This is also a major focus of the quarterly peer center meetings previously mentioned.

4. **How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?**

   Increase in the number of both Block Grant and State grant funded opportunities supporting recovery-oriented programs, BBHHF technical assistance made available to these programs as well as the provision of web-based and phone support in the identification and navigation of services.

Housing

1. **What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?**

   The housing needs of persons served is a major focus of the recently reactivated West Virginia Interagency Council on Homelessness. The West Virginia Interagency Council on Homelessness was established in May 2004 by Executive Order No. 9-04. In April 2007, then-Governor Joe Manchin re-established the Council through Executive Order No. 4-07, with the Office of Economic Opportunity to serve as lead agency. The council seats were appointed by the governor and included over 20 members. The council focused on updating the action plan to end homelessness and last met on October 16, 2009. Under new leadership at the Office of Economic Opportunity, it was recommended the council be transferred to the West Virginia Department of Health and Human Resources (WDHHR) Bureau for Behavioral Health and Health Facilities.

   On November 21, 2013, Governor Earl Ray Tomblin issued Executive Order No. 9-13 and re-established the West Virginia Interagency Council on Homelessness, with the Bureau for Behavioral Health and Health Facilities as lead agency. In February 2014 the revitalized West Virginia Interagency Council on Homelessness held its kickoff meeting. Council members reviewed their charge as outlined by Executive Order 9-13. The work of the prior council was reviewed along with the Federal Strategic Plan to End Homelessness *Opening Doors.*

Subsequent meetings focused on the development of the Work Group/subcommittee composition based on a population focus. In June 2014 WVICH hosted a two-retreat with all subcommittee members. On the first day of the retreat, US Interagency Council on Homelessness (USICH) Regional Coordinator Amy Sawyer presented on the goals and themes of *Opening Doors* as well as the work and roles of USICH and state councils. Background information on the Continua of Care, HMIS, and Emergency Shelter System were also presented. The second day of the retreat focused on the work of state agencies and the homeless services they provide. Through a facilitated discussion participants articulated their values and the Council and subcommittee members agreed to adopt the six USICH goals with additions. In population focus subcommittees, participants then completed a SWOT Analysis (Strengths, Weaknesses, Opportunities, Threats) of homeless system and services in West Virginia.

The Council and subcommittees met again in September 2014. During this meeting participants reviewed criteria for the population focus subcommittee report sections. Participations also developed online survey questions to gather input from the WV Housing Conference attendees and general public pertaining to homeless services in West Virginia. (To date 167 responses have been received from the online public survey; plus 36 members of WVICH and subcommittees have responded.) Participants received a presentation from Jane Vincent, Regional Administrator, HUD. In November 2014, WVICH held a two-day retreat for Council and subcommittee members. During the retreat, subcommittees developed population-focused recommendations and general WVICH themes. Subcommittees have developed and submitted their population-focused report sections with recommendations. Subcommittee members have held additional meetings and conference calls outside of the WVICH-hosted meetings. A program report was released in early 2015 with additional work on the plan to continue throughout the year

Additionally, BBHHF is coordinating meetings with housing and homeless service programs and behavioral health providers, encouraging the change in mind-set that treatment does not always mean a bed, and providing more funding for recovery residences. BBHHF uses State funds to support Community Engagement Specialists at both the CBHCs and a number of housing providers who devote a disproportionate percent of their time to helping people obtain and maintain housing of choice in the most integrated setting possible. Finally, West Virginia's Money Follows the Person program, Take Me Home, West Virginia, has carved out a pilot population of people to serve with serious mental illness who are transitioning from state hospitals for both Transition Navigator and Supported Housing Services, using the Permanent Supportive Housing toolkit fidelity scale. This model is grounded in the following principles: Choice in housing and living arrangements; Functional separation of housing and services; Decent, safe and affordable housing; Community integration and rights of tenancy; Access to housing and privacy; and, Flexible, voluntary, and recovery-focused services.

2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?

Peers will be employed in recovery residences, homeless shelters, and at housing agencies. Additional drop-in centers will be added statewide and more screening and brief interventions will be provided for people experiencing homelessness. Incorporation into a supportive community is also a priority for the West Virginia Interagency Council on Homelessness as they are working toward the formation of a strategic statewide plan. Consumer driven and focused services and housing is one of the core values and principles of the state's plan.

Furthermore, BBHHF is actively working with the West Virginia Coalition to End Homelessness to encourage all of its partner agencies to adopt the Permanent Supportive Housing and Housing First approach in the applicable circumstances.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

17. Community Living and the Implementation of Olmstead

The State's Olmstead Plan, *Building Inclusive Communities: Keeping the Promise*, is in the course of being updated by the newly hired Olmstead Director as it has not been revised since being approved by Governor Joe Manchin in 2005. The Plan's goals are sorted by the different components of monitoring and maintaining state compliance with the Olmstead decision, including Informed Choice, Identification, Transition, Diversion, Reasonable Pace, Eliminating Institutional Bias, Sell-Direction, Rights Protection, Quality Assurance, and Community-Based Services, programs and Activities.

Section V of the Plan summarizes the State's existing Community-Based Programs & Supports, including but not limited to Medicaid and state-funded services and supports, such as the state's three Medicaid-funded 1915 (c) Home & Community-based Waiver programs, state and Block Grant funded Peer Support and Independent Living services, and state and HUD funded housing supports. Section VI, Past Successes & Future Challenges, includes a subsection on Funding Institutional & Community-Based Supports, which includes subsections on both Money Follows the Person and Mental Health Services.

It should be noted that neither of these sections incorporates programs added during the past ten years, such as the CMS Rebalancing Demonstration-Take Me Home WV grant, the Administration for Community Living No Wrong Door planning grant, and SAMHSA's BRSS-TACS Policy Academy and this year's BRSS-TACS grant for the Expansion of Policy Academy Action Plans.

People are able to transition from hospitals back to the community in West Virginia using a variety of approaches, including Take Me Home WV Transition Navigators, Care Supports (which include a peer support option) and Community Transition Services and Goods and Services, state Olmstead Transition and Diversion funds (which, as the name implies, can be used to keep people out of facilities and to bring people back to the community from facilities), Legal Aid of West Virginia's Behavioral Health Advocates, BBHHF funded Community Engagement services and family and community support funds, Northern West Virginia Center for Independent Living's Community Living Services Program and Medicaid funded Targeted Case Management. It should be noted that the current demand/requests for transition supports and services exceeds the available supply and the Olmstead Office is actively tracking down additional funding and resources.

Between the US Supreme Court Olmstead decision and the ongoing Kanawha County Circuit Court Hartley case, West Virginia has taken numerous steps to help people with behavioral health issues access and stay in their most integrated settings, including but not limited to increasing the number of Medicaid funded Assertive Community Treatment providers, enhancing state-funded community based services and supports, such as detoxification and crisis stabilization units, supportive housing units and group homes, homeless outreach and engagement services, peer recovery supports, Transition Navigators and Community Engagement services and the accompanying funds referenced above, most of which are available during and following transitions, and day supports and Supported Employment.

Furthermore, BBHHF has just awarded grant funding to First Choice Health Systems for the development and operation of a 24/7 Behavioral Health Information, Referral and Outreach Call Center to improve access and immediate referral to appropriate levels of care and improve consistency in referral mechanisms and access to appropriate community supports.

In a June 1, 2015 letter to Governor Tomblin the U.S. Department of Justice noted, by way of background, that on "April 29, 2014, we notified you that we were initiating an ADA investigation of West Virginia's programs for children with mental health conditions. We visited the state four times (June 2-3, July 28-August 1, September 22-24, and November 3, 2014) to assess the system of care for children with mental health conditions" and the letter concluded that "West Virginia fails to provide services to children with significant mental health conditions in the most integrated settings appropriate to their needs in violation of the ADA. The State has needlessly segregated thousands of children far from family and other people important in their lives. With adequate services, the State could successfully treat these children in their homes and communities. The systemic failure to develop critical in-home and community-based mental health services also places children with mental health conditions who currently live in the community at risk of unnecessary institutionalization."

Finally, the letter laid out a series of recommended remedial measures, including expanding in-home and community-based mental health service capacity; eliminating unnecessary use of segregated residential treatment facilities (it may be worth noting that there are no state-operated children's hospitals or residential treatment facilities in West Virginia); ensuring that the CBHCs provide for (directly or indirectly) in-home and community-based mental health services across the state using evidenced-based approaches; designating a single Intensive Care Coordinator to coordinate cases where a child is involved in multiple child-serving systems; developing an interagency decision making and oversight entity to improve coordination of and access to intensive mental health services; modifying policies and practices to ensure the effective engagement of families as full partners in the assessment, planning, and implementation of services and supports; providing families, children and youth with accurate, timely, and accessible information regarding the services available in their communities; developing and implementing a cross-system remedial plan; and, assessing each individual placed in segregated residential treatment facilities by or funded by DHHR.

In response to this letter, the head of DHHR, Secretary Bowling, has directed the Bureau Commissioners and staff to work together to develop a coordinated Work Plan to address the concerns raised by the DOJ in their letter. This plan will incorporate resources from BBHHF as well as the state Child Welfare, Medicaid and Public Health agencies. In addition, the State Olmstead director is working with the Olmstead Council to update the State Plan and to more comprehensively address families of children with SEDs and children's mental health services and supports.

According to Secretary Bowling, "Historically, our state has removed more children from the home due to abuse, neglect, and juvenile proceedings and has one of the highest percentages in the nation of children placed in congregate care settings," she said. "For the past two years, my

team and I have been working diligently to implement plans to turn these statistics around. In collaboration with the Courts, the Legislature, providers and families, we must continue this progress. She said West Virginia's Bureau for Children & Families was awarded a waiver in October to allow it "more flexibility in delivering services to children and their families."

"Through this waiver, BCF is working to reduce its reliance on residential care placement with a demonstration project called Safe at Home West Virginia. The Department's goals with Safe at Home are to provide wrap around services to children within their own communities to ensure they are healthy, safe and successful."

DHHR also is partnering in a comprehensive, national initiative sponsored by the National Governors Association Center for Best Practices, the National Conference of State Legislatures, the National Council of Juvenile and Family Court Judges, the National Center for State Courts, and Casey Family Programs to develop a plan to improve the well-being of children in foster care. "Toward this goal, the West Virginia Core Team, made up of more than 70 public and private stakeholders, has formed work groups to assess issues and explore options," she said. "The work groups are examining topics including a foster child's access to medical and behavioral health services, timely and comprehensive health screenings, utilization of psychotropic medications for children in congregate and foster care, ways to safely reduce out-of-home placements, and reduction of the incidence of drug addicted babies placed in out-of home care."

Preventive and early intervention programs as well as expanded community-based mental health services for children and families are being developed, she said, and funding is being reallocated "to ensure that necessary child services are available in communities across the state."

Bowling also said access to mental health services for children and families has been expanded, and the agency also is encouraging positive parenting and promoting child development programs.

Finally, BBHHF has a number of ongoing partnerships with other agencies that focus on community integration, including but not limited to ongoing coordination and planning meetings with the agency’s sister bureaus, Child Welfare, Medicaid and Public Health, criminal justice entities via the State’s Justice Reinvestment initiative (or JRI), the Governor’s Advisory Council on Substance Abuse, Regional Task Forces, Developmental Disabilities Council and Behavioral Health Planning Council, the Statewide Independent Living and State Rehabilitation Councils, the Olmstead Council, the Take Me Home WV Steering Team and Advisory Council, and the Bureau of Senior Services’ No Wrong Door Steering Committee and Advisory Council.

Environmental Factors and Plan

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with more than 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious mental, substance

use, and co-occurring disorders?

3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

[91] Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[92] Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[93] The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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[95] Department of Health and Human Services. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions: Joint CMS and SAMHSA Informational Bulletin. Available from http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

18. Children and Adolescents Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance abuse disorders?

An effective child and youth service system must provide for an integrated and coordinated array of community based services which promotes wellness, recovery and resilience. The Bureau for Behavioral Health and Health Facilities is embedding system of care values into requests for new services (Announcements of Funding Availability), grant agreements for existing services, and all training and technical assistance offered to providers, families and community members. For example:

- All BBHHF grantees must demonstrate compliance with training and service standards consistent with a system of care approach: individual and family engagement; person-driven/centered plans of care; cultural competency; trauma-informed services; consumer feedback/satisfaction.
- A statewide behavioral health plan is under development that identifies a comprehensive array of services for children with serious emotional disorders, using nationally recognized and evidence based/informed service models. The plan recognizes the need to shift service capacity from being residentially "top heavy" to offering more regional and community-based non-residential services and supports.
- The statewide plan is guiding the redistribution of funds. State funding, made available for redirection as a result of Medicaid expansion, is targeted for gaps in community-based services, such as peer supports, in-home visitation, and intensive care coordination, and supporting "infrastructure" such as interagency planning teams and cross-agency clinical case reviews.

The Bureau is partnering with the state agencies responsible for public education, juvenile corrections and child welfare to develop consistent standards and outcomes for the various federal and state grants that support school-based services designed to prevent students from becoming involved with or deepening their involvement with the juvenile justice system.

The Bureau is partnering with WV's early childhood system to coordinate efforts to address emotional, social and behavioral well-being of our youngest citizens and their families. Practice standards and outcomes are being established through the WV Infant Mental Health Association that can be tracked and monitored across multiple systems (mental health, substance abuse, child welfare, health, early care & education) that serve very young children and their families.

All of the above examples have the common denominator of bringing together state and community organizations to develop and implement services that are consistent with system of care values and principles.

The BBHHF is committed to improving evaluation services for the Mental Health and Substance Abuse Block Grant, as well as for other key initiatives supported with state revenue dollars. The BBHHF plans to release a Request for Proposals (RFP) in the next 3 months for Evaluation of the Mental Health and Substance Abuse Block Grant.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

BBHHF is developing developing and disseminating standards of care, policies and protocols to guide best practices for children, youth and adults with behavioral health needs. Standards of care will address individualized care planning, as well as other best practices, to improve the child and adolescent service delivery system.

In collaboration with other governing and licensing bodies, particularly the Bureau for Children and Families, the BBHHF is promoting use of the Child and Adolescent Needs and Strengths Assessment (CANS) to conduct initial assessments for children and youth receiving publicly funded services. The CANS assessment results drive development of an individualized, multidisciplinary service plan that addresses the needs of each child across a variety of clinical and life domains. All new children's services grantees must assure CANS-certified staff are employed to implement and teach CANS as an assessment and planning tool.

Youth transitioning to the adult service system who are at risk for homelessness or commitment to a psychiatric facility will be assessed by the adult version of the CANS: The Adult Needs and Strenghts Assessment (ANSA) and recommendations for an integrated, personalized plan of services and supports will be offered.

The child and adolescent service system will include a State Funded Youth Service Center (YSC) located in one region of the state that will serve as a model for the implementation of the cross-system, collaborative approach. The YSC will operate in conjunction with five (5) other Regional Youth Service Centers to create the statewide Behavioral Health Youth Services Network. The YSC will provide a variety of treatment and non-treatment options for youth with substance abuse and/or co-occurring disorders. Programming will include: Primary Prevention, Promotion & Wellness, Engagement Services, Outpatient Services, Medication Services, Community Support Services, Recovery Support Services, Intensive Support Services, and Out of Home Residential and Transitioning Young Adult Residential services. In addition, the YSC will include a statewide learning laboratory for professional development, a Referral & Outreach Center, an Engagement (Diagnostic) & Outpatient Clinic, and a Transitional Young Adult Residential Program. The Substance Abuse Mental Health Administration (SAMHSA) Block Grant will provide funding for five (5) regional coordinated programming offered to the

communities through an Announcement Funding Availability (AFA) process. The regional YSCs will be modeled after the State Youth Service Center, with the exception of the Transitioning Young Adult Residential programming, and will be responsible for receiving intakes for "close to home," regional service placement. The regional YSCs will provide individual services, building on the strengths of youth and their families, delivered in the least restrictive environment, incorporating evidence based practices, and offer effective cross-system collaboration, including integrated management of service delivery and cost.

3. How has the state established collaboration with other child and youth serving agencies in the state to address behavioral health needs (e.g. child welfare, juvenile justice, education)?

Partnerships and collaboration among public and private systems, as well as with individuals, families, agencies and communities, are essential components of an effective system of care for children and adolescents with or at risk for serious emotional disturbances (SED), co-occurring substance abuse and/or co-occurring intellectual and developmental disabilities and their families. The role of the Bureau for Behavioral Health and Health Facilities (BBHHF) as the State Mental Health (SMHA) and Single State Authority (SSA) is to provide leadership in the administration, integration and coordination of the public behavioral health system.

In collaboration with the Bureau for Children and Families, the BBHHF's, West Virginia System of Care (WVSOC) Initiative has created a significant cross system partnership. The WVSOC is a public /private /consumer partnership, dedicated to the mission of building the foundation for an effective coordinated and integrated service delivery system that empowers children and adolescents at risk of out of home care and their families. The WVSOC approach, including a a spectrum of effective, trauma informed community based services and supports for children and youth with or at risk for behavioral health challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to help them function better at home, in school and in the community, provided the vision and guidance to achieve the progress noted in #1 above.

West Virginia was the recipient in 1999 of a federally funded (Service Administration for Mental Health and Substance Abuse), five year WV System of Care pilot project for a 12 county region in West Virginia. In 2005, West Virginia Lawmakers enacted legislation that established the Commission to Study the Residential Placement of Children (West Virginia Code §49-7-34). In 2010, the West Virginia Legislature passed Senate Bill 636 to reconstitute the Commission. The Bill included addressing any ancillary issues relative to foster care placement and mandated a reduction in out of state placements for children and youth. The Commission's findings resulted

in the continuation and statewide expansion of the WVSOC philosophy and strategies, as one part of the Commission's final 13 recommendations.

Using the framework and partnerships promoted by the WVSOC, the WVDHHR Bureau for Children and Families was recently awarded a Title IV-E Waiver to conduct a Demonstration Project in October 2014 by the United States Administration for Children and Families, Children's Bureau. The waiver will be used to implement a child welfare reform project called Safe at Home West Virginia. The Waiver Demonstration is designed to reduce reliance on residential care by ensuring youth remain in or return to their own communities whenever safely possible. Safe at Home will initially focus on youth 12-17 years old from 11 counties in West Virginia who live in congregate care. Statistics indicate that most of these youth have one or more behavioral health diagnoses.

Consistent with system of care philosophy, the initiative will bring children and their families together to identify formal and informal supports that would help reunify them and keep youth in their communities. Through Safe at Home West Virginia, providers will be able to serve families with more flexible, targeted, and individualized services, including

- Trauma-informed assessments for youth and their families to identify their needs.
- Trauma-informed wraparound services.
- Evidence-based services and supports.
- Opportunities to provide services early and often, aligned with the targeted needs of youth and their families.

This effort requires youth-serving public and private organizations to partner, innovate, and develop a shared commitment to transform the way we serve families. Key partners include families, child welfare, behavioral health, the courts, schools, probation, service providers, and others.

Over the coming 12 months, the BBHHF will begin to "mirror" this collaborative process of reducing reliance on residential care, targeting children in parental custody (rather than state custody), by identifying children currently served in out of state psychiatric residential treatment facilities (PRTFs) due to lack of less intensive treatment alternatives in their home community. We are currently collecting data about the number of youth placed in Medicaid-reimbursed out of state PRTFs who are in parental custody to better understand the range of behavioral health issues for which they were referred.

The BBHHF submitted a proposal in response to the recently released Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), for Cooperative Agreements for State Adolescent and Transitional Aged Youth Treatment Enhancement and Dissemination. The purpose of this grant is to provide funding to states/territories/tribes to improve treatment for adolescents and transitional aged youth, through the development of a learning laboratory with collaborating local community-based treatment provider sites. Through the shared experience between the state and community-based treatment provider sites, an evidence-based practice (EBP) will be implemented, adolescents, transitional aged youth, and their families/primary caregivers will be provided services, and a network will be developed to enable the state and the sites to identify barriers and test solutions through a services component, operating in real time. System outcomes will include: changes to state policies and procedures; development of financing structures that work in the current environment; and, an assessment and treatment blueprint for states and providers that can be used throughout the state to widen the use of effective EBPs. Additionally, youth (ages 12-18), transitional aged youth (ages 18-24), and their families/primary caregivers will be provided services from the grant funds, which will help inform the process on systems issues needing improvement. State Youth Treatment cooperative agreements involve both state infrastructure development/improvement and direct service delivery components. All activities share a common goal of building a solid foundation for sustaining an effective, integrated adolescent and transitional aged youth treatment and recovery support services system. The BBHHF is optimistic that West Virginia will be one of the states awarded this unique funding opportunity, however, the State is committed to moving forward with a regional approach to better serving the needs of West Virginia's children and adolescents and their families either with or without the support of the SAMHSA Grant award.

4. How will the state provide training in evidence based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?

The BBHHF recognizes the value of a train the trainer model, when appropriate, to effectively build and sustain regional and statewide infrastructure and workforce capacity. The BBHHF will continue to provide a variety of training opportunities on evidence based mental health and substance abuse prevention/promotion; treatment approaches, such as motivational interviewing; and, recovery services for children and adolescents. The BBHHF Regional Substance Abuse Prevention Grantees coordinate and offer a multitude of training opportunities on evidence based mental health and substance abuse prevention and promotion for children and adolescents.

The technical assistance partnership with the National Center for Trauma Informed Care (NCTIC) will greatly assist West Virginia in building workforce and service capacity for trauma

informed care. The partnership with the NCTIC will provide invaluable technical assistance and training opportunities across the state, to specifically address trauma informed care for BBHHF's priority populations. The BBHHF will disseminate information on training opportunities and will promote evidence based programs and practices, SAMHSA's National Registry on Evidence Based Programs and Practices (EREPP) and web based training and best practice toolkits/curriculums available on the National Children's Traumatic Stress Network (NCTSN). We are planning periodic clinical supervision/case consultation sessions through the Regional Youth Service Centers this fiscal year to promote peer support and sustainability of skills.

In addition, the West Virginia System of Care will offer a variety of evidence based/best practice training, including: the Family Driven Care Toolkit, Family Centered Practice, Family and Youth Engagement Strategies, Mental Health Promotion and Stigma Reduction, Youth Suicide Awareness and Prevention, Cultural and Linguistic Competency Toolkit, and Trauma Informed Care Toolkit. The Adolescent Suicide Prevention and Early Intervention (ASPEN) Program and the West Virginia Council for the Prevention of Suicide (WVCPS) also coordinate and provide a variety of training on best practices across the continuum of suicide prevention, early intervention, treatment and postvention, including: Question, Persuade and Refer (QPR) Gatekeeper Training for Suicide Prevention; Suicide Alertness for Everyone (safeTALK); Signs of Suicide (SOS) Middle School Program; Applied Suicide Intervention Skills Training (ASIST); Assessing and Managing Suicide Risk (AMSR); and, Counseling on Access to Lethal Means.

An emerging area of focus is children with co-existing mental health and intellectual disabilities, particularly those who have experienced trauma. We are offering several staff development opportunities to child welfare, behavioral health, juvenile justice and education professionals, including Introduction To Serving Children With Co-Existing Disorders, Developing Therapeutic Relationships With Individuals With Asperger's, and a multi-day "intensive" for therapists serving children on the autism spectrum.

5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

The BBHHF is committed to improving outcomes for children and adolescents with behavioral health challenges (substance abuse, mental health, and intellectual/developmental disabilities), many of whom are primarily served through the child welfare system.

The BBHHF will develop policies to ensure that the child and youth service system provides individualized strength based services, in the least restrictive environment, incorporating evidence based practices and effective cross-system collaboration. Based on extensive research in the field of youth treatment services, SAMHSA has documented clinical and functional outcomes for this population, including increases in behavioral and emotional strengths, reduction in suicide attempts, improvement in school performance and attendance, fewer contacts with law enforcement, reductions in in-patient care, and more stable living

situations. Outcomes have also been evaluated at the family level, including reduced caregiver strain, more adequate array of resources, fewer missed days of work due to behavioral health needs and crisis of the child, and improvement of overall family unit functioning. BBHHF's grant agreements include specific statements of work outlining the service to be delivered, how it meets standards of evidence-based practice and the expected outcomes, the population to be served, and targeted budgets to support the service.

The BBHHF is developing technical assistance policies for our grantees that will be implemented by both peers (those with lived experience) and professional teams from the Bureau to ensure that the child and youth service system provides individualized strength based services, in the least restrictive environment, incorporating evidence based practices and effective cross-system collaboration, as described earlier. Monitoring will be further strengthened by our licensing and regulatory partners who play a formal role in quality oversight of the service system.

Environmental Factors and Plan

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG 19: Pregnant Women and Women with Dependent Children

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this. All funded providers are required within in statement of work (contracts) that this population is prioritized and preferential **treatment is provided.**

2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours. All grantees serving the population will provide services within 48 hours as a required within their statements of work (contracts).

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services. A daily bed application is provided to the State and network referrals are completed with those providers serving women. The expansion of recovery residences are supporting he interim service periods if the woman is assessed to need residential care. The initiation of the Statewide Help and Referral Call Center in September 2015 will also support this effort in providing close to home services in and outside of the BHHF provider network.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3. BHHF monitoring and compliance office

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.) *BHHF FUNDED PROGRAMS ONLY*

Thirteen Comprehensive Community Behavioral Health Centers are required to offer a full continuum of publically provided Behavioral Health Services. Out-Patient Services include: Assessments, Individual, Group and Family Therapy and Medication Management. Residential Treatment Facilities are limited and prioritized for intravenous (IV) drug users, women who are pregnant, transitioning aged youth, and individuals being transitioned from a higher level of care. These facilities provide clinically managed, high intensity services that feature a planned regimen of care in a safe, structured and stable environment. Residential programming is gender specific, trauma informed and in coordination with day habilitation, rehabilitation and peer supports.

TREATMENT AND RECOVERY SERVICES/CAPACITY CHANGE

DESCRIPTION	2012	CURRENT
Regional Youth Service Centers	0	6 Locations
Change in number of Detox Stabilization	10 locations, 104 beds	13 locations, 130 beds
Change in number of Treatment and Recovery Residences by level	31 locations, 409 beds (no levels)	40 locations, 759 beds Residential Treatment

		Facility 8 Locations, 102 Beds Treatment Provider Recovery Facility (Level 4): 13 locations, 195 beds Peer-Operated Recovery Facility (Level 3): 4 locations, 280 beds Peer-Operated Recovery Home (Level 2): 15 locations, 182 beds
Telehealth Medicaid Reimbursement Capacity	Limited Medical Services only	All Clinic and Rehab BH Codes with Telehealth Options

With regard to *Medication Assisted Treatment*, there are currently 187 physicians who are waivered to prescribe buprenorphine. WV Medicaid provides coverage for buprenorphine, mono-buprenorphine and vivitrol. There are currently 165 physicians that are licensed under Medicaid to provide these services.

a. How many of the programs offer medication assisted treatment for the pregnant women in their care? All 9 Opioid Treatment Centers provide MAT for pregnant women and the 4 residential programs.

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they? There are providers in every region of the State. Some private physicians are not comfortable caring for pregnant women particularly if she has been on methadone.

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP) WV has 4 residential programs for women and their children as well as recovery residences totaling 90 beds for the women and in some of those programs they may bring their babies. The biggest barrier to program completion is no smoking facilities. More than 26% of pregnant women smoke during pregnancy,.

a. How many of the programs offer medication assisted treatment for the pregnant women in their care? All BHHF treatment programs offer MAT.

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they? Southern West Virginia continues to have the greatest need identified that includes the Governor's Sub-State Planning Region 6.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Preventing Suicide in West Virginia

a plan to address a silent epidemic

Prepared by the West Virginia Council for the Prevention of Suicide for

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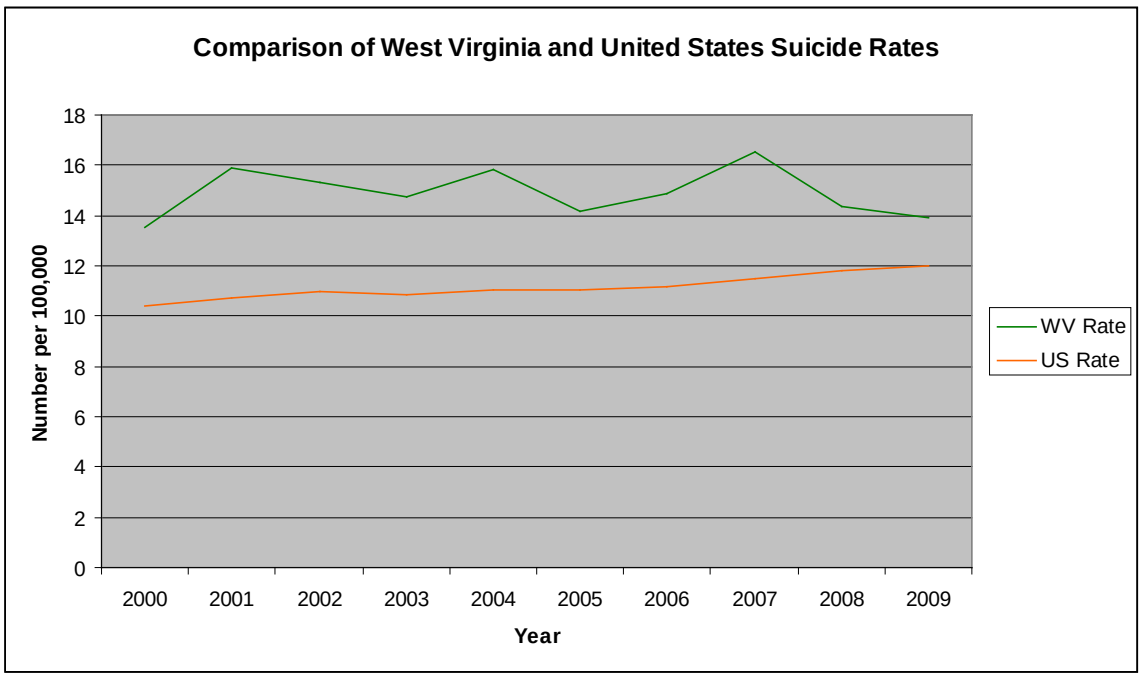
Introduction

Suicide is a significant problem in the United States and in West Virginia. It has been called "a *silent epidemic*"[1] that "exacts an enormous toll from the American people."[2]

On average, about 32,000 individuals in the United States died from suicide each year in the years 2000-2009. Another 650,000 receive emergency care after attempting to take their lives.[3] It is estimated that one person dies every 14.2 minutes due to suicide.[4]

Data show that 2,723 individuals in West Virginia died by suicide from 2000-2009. West Virginia's suicide rate was higher than the national average in number of persons per 100,000 population who died by suicide in that time period.[5]

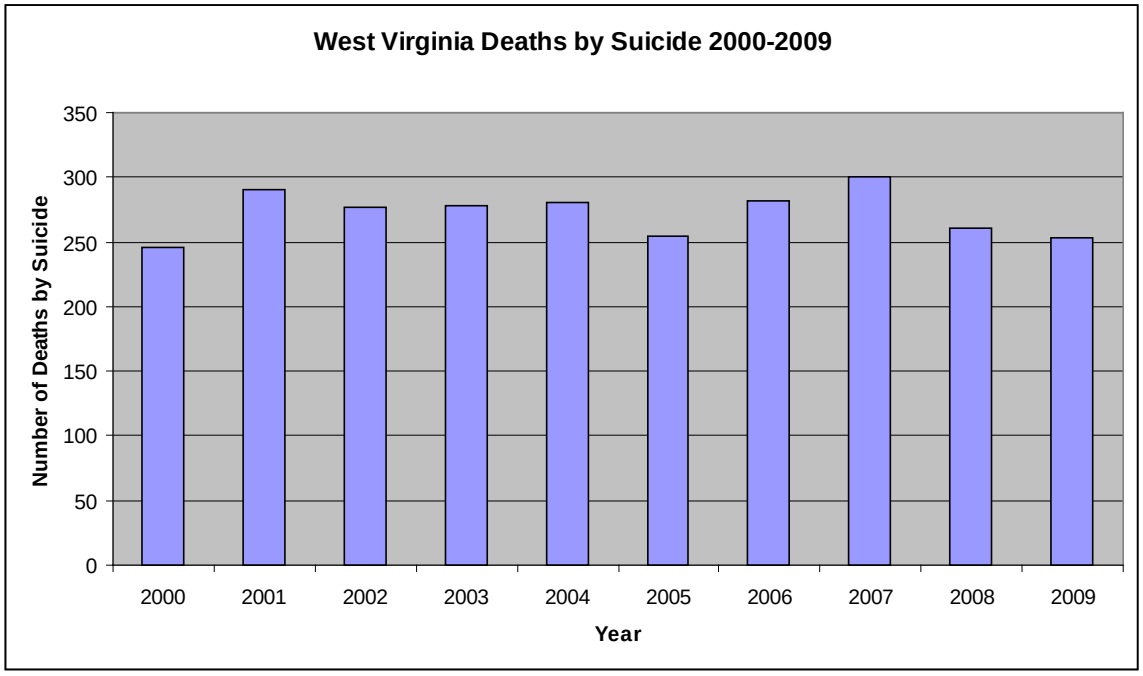


"Number per 100,000" provides a statistic which enables a comparative analysis across states. Actual numbers produce a picture for the specific state, such as West Virginia. The chart below depicts the number of suicides for the years 2000 through 2009. It ranges from 246 reported

[1] See http://www.pbs.org/thesilentepidemic/
[2] U.S. Department of Health and Human Services, Public Health Service. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action.*
[3] Ibid.
[4] See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf

[5] Found at http://www.cdc.gov/injury/wisqars/fatal.html

deaths by suicide in 2000 to 300 deaths in 2007; more than one person died from suicide every two days in those 11 years.[6]



Intentional self-harm was the second leading cause of death among West Virginia males aged 15 to 24 in 2009, according to the Centers for Disease Control it was exceeded only by accidents.[7] Statistics indicate that deaths by suicide affect younger West Virginians most.[8] These data indicate that just over 1% of the deaths in 2002 and 2003 were due to intentional self-harm, but 5% of the years of potential life lost before age 65.

Young people are not the only ones who die from suicide. There were 178 deaths among West Virginians aged 25-64 in 2009 attributed to intentional self-harm, about 23% of the 789 deaths in that age group in that year. About 81% of those deaths were males.[9]

Suicide also affects older people aged 65 and older, although that is not listed by the Bureau of Public Health as a "leading cause" of death in West Virginians in that age group. Nationally in 2009, 5,858 older Americans died by suicide.[10] This averages out to 1 older

People of all age groups attempt suicide, but older adults have a higher completion rate.

[6] Ibid.
[7] See http://webappa.cdc.gov/sasweb/ncipc/leadcaus10.html
[8] See http://www.wvdhhr.org/bph/oehp/vital03/vs_30.htm
[9] See http://www.wvdhhr.org/bph/oehp/vital03/vs_31x.htm
[10] See http://www.cdc.gov/injury/wisqars/fatal.html

American suicide death every 1 hour and 30 minutes.

Although older adults nationally and in West Virginia attempt suicide less often than those in other age groups, they have a higher rate of suicide. Older Americans are more lethal in their attempts and die by suicide more often. For all ages combined, there is 1 suicide for every 20 attempts nationally. Among people aged 15-24 years old, there is 1 completed suicide for every 100-200 attempts. Over the age of 65, there is 1 completed suicide for every 4 attempts.[11]

Nationally, suicide deaths consistently outnumber homicide deaths by a margin of two to one. In 2002, twice as many Americans died from suicide than from HIV / AIDS. But research has shown than 90 percent of people who die by suicide have depression or another diagnosable (and treatable) mental illness or substance abuse disorder. [12] This suggests suicide can, and is, preventable.

Efforts at preventing suicide began nearly a half-century ago, when the first suicide prevention center established in Los Angeles. This center, and many others established after it, offered community service and crisis intervention.[13] In 1996, Gerald and Elsie Weyrauch of Marietta, Georgia began a grassroots effort to encourage public education and awareness, community action and grassroots advocacy to prevent suicide. The Weyrauch's 34-year old physician daughter died by suicide and the couple adopted a goal to create a way for people who have lost someone to suicide to transform their grief into positive action to prevent future tragedies.[14]

In the 10 years since that initial effort,, nearly every state has developed and implemented efforts to prevent suicide. A national hot line, to respond to individuals contemplating suicide, has been established. National and state conferences have shared information on suicide prevention, crisis intervention, and outreach methods. The country's Surgeon General has issued a report and a national strategy for suicide prevention has been developed

This plan has been prepared by the WVCPS for the West Virginia DHHR

Suicide prevention awareness and advocacy efforts in West Virginia began in 2001, with a small grant to Valley HealthCare System in Morgantown from the West Virginia Department of Health and Human Resources to create the

[11] See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf
[12] http://www.spanusa.org/index.cfm?fuseaction=home.viewPage&page_id=8A13146B-E70F-213B-95A0CE83BC5518F6
[13] Op Cit U.S. Department of Health and Human Services, Public Health Service. 2001
[14] See http://www.spanusa.org/C_about-span.html

HOTT (Helping Our Teens Thrive) Coalition. Two years later, the West Virginia Council for the Prevention of Suicide (WVCPS) was formed. The mission of the Council is to, "Reduce suicides in West Virginia and address the needs of survivors of suicide loss through evidence-based programs and practices in order to prepare communities, recognize, and support those at risk for suicide and survivors of suicide loss." The vision of the Council is that West Virginia not lose one citizen to suicide.[15]

In the intervening years, the HOTT Coalition and the WVCPS have presented numerous workshops and conferences for educators, health and behavioral professionals, and social service providers. The Council has also sponsored the development of age-appropriate assessment protocols for early identification of potential suicide victims and referrals to services.

This Plan has been prepared by the WVCPS for the Department of Health and Human Resources after review and comment by several interested groups.

[15] See http://www.wvsuicidecouncil.org/

Purpose of this Plan

The vision of the West Virginia Council on Suicide Prevention is that "West Virginia does not lose one citizen to suicide." It is the hope that this Plan will provide guideposts to working toward that vision.

Many suicides can be prevented by developing protective factors and reducing risk factors. Protective factors include effective and assessable clinical care for mental, physical, and substance use disorders; strong connections to family and community support; skills in problem solving, conflict resolution, and nonviolent handling of dispute; and cultural and religious beliefs that discourage suicide and support self-preservation. Risk factors include mental illnesses; history of trauma or abuse; family history of suicide; job or financial loss; loss of a relationship; lack of social support; stigma associated with seeking help; and exposure to others who have died by suicide.[16]

No agency or organization can fully address the problem – it requires the attention, effort, and coordination of multiple organizations, groups, and individuals. These include organizations, agencies, and individuals providing mental health services; health care providers, school systems and universities, law enforcement; court officials; senior citizen organizations; faith-based organizations; and groups of families and friends of people who have died by suicide.

While representing a new and coordinated endeavor, the Suicide Prevention Plan builds on current activities and endeavors, hopefully avoiding a duplication of effort at a time when resources are limited. The work of the WVCPS has been based on this coordination of existing resources. It is believed this plan will guide further development of these efforts, leading West Virginia toward achieving the Council's vision.

This plan builds on current activities and endeavors.

This plan has been provided for review to the West Virginia Mental Health Planning Council, the West Virginia Behavioral Healthcare Providers Association, the West Virginia Primary Care Association, and other health, social service, and education providers and organizations. It is hoped that this process will lead these organizations and individuals to considering the recommendations for addressing this *silent epidemic*.

[16] U.S. Department of Health and Human Services, Public Health Service. 2001. *National Strategy for Suicide Prevention: Goals and Objectives for Action.*

Also, upon acceptance by the West Virginia Department of Health and Human Resources, the WVCPS is hopeful the recommendations will guide Department-wide and State-wide efforts to reduce suicides.

Development Process

In 2001, Valley HealthCare System responded to an Announcement of Fund Availability from the Children's Division of the Office of Behavioral Health Services in the West Virginia Department of Health and Human Resources Bureau for Behavioral Health and Health Facilities. Valley HealthCare System proposed the development and implementation of a public awareness and information project to create awareness and understanding of a *silent epidemic*: suicide among adolescents in West Virginia.

The small grant, funded through the Community-Based Mental Health Services Block Grant, enabled the creation of the Helping Our Teens Thrive Coalition (HOTT Coalition). This coalition was composed of representatives of health and behavioral health providers, educators, and interested individuals. In the beginning years, several seminars and workshops were provided to alert school personnel and the interested public in the number of children who were dying by suicide in West Virginia as well as what was needed to prevent such untimely and tragic deaths.

The workshops and seminars were well received and the HOTT Coalition was re-formed and expanded into the West Virginia Council for the Prevention of Suicide. The WVCPS understood that people of all ages die by suicide. The "target population" addressed by the WVCPS was expanded to include adults and the Council began providing bi-annual conferences which attracts several hundred health and behavioral health providers and other individuals. A Website (http://www.wvsuicidecouncil.org/) has been created, providing statistics and information on suicide and offering help for individuals in crisis. The Council has developed awareness curriculums covering all age groups, and currently provides workshops covering the entire lifespan.

The WVCPS has a Website: www.wvsuicidecouncil.org

In addition to information and education, the Council sponsored the development of protocols for suicide assessment, including the Adolescent Screening and Assessment Protocol-20 (ASAP-12), the Suicidal Adult Assessment Protocol (SAAP), and the Suicidal Older Adult Protocol (SOAP) [17].

The plan is based on the goals and objectives in the *National Strategy for Suicide Prevention Goals and Objectives for Action*. Specific goals and

[17] See http://www.wvsuicidecouncil.org

objectives, strategies, and activities for implementation were drafted by the Council membership and circulated for review and comment to stakeholder groups and individuals. Officials in the Department of Health and Human Resources have reviewed and commented on the plan and have now adopted it as the West Virginia State Plan for Suicide Prevention.

Implementation of the plan is a shared responsibility. Certainly, the Council will play a major role in coordinating efforts in achieving the plan. But all stakeholders – providers of health and behavioral health services, teachers, higher education, law enforcement, the courts, families and friends of people who have died by suicide and the general public have roles in preventing untimely and tragic deaths.

Priority Populations

This plan addresses suicide prevention for all persons in West Virginia, regardless of age, race, or gender. Data from 2009 indicates that West Virginia's 253 reported deaths by suicide were equal to 113.9 suicides per 100,000 population, the 20th highest in the United States.[18] However, some population groups are more at risk than others.

The Center for Disease Control publishes data showing the number of suicides by age group. The following chart shows deaths by suicide for the years 2000 through 2009, divided into four age categories.
Over the past ten years there were a reported 2,723 reported deaths by suicide in WV. This works out to an average of 272 deaths by suicides a year in WV. Over this ten year period the year with the lowest reported number of deaths by suicide was 2000 with 246 reported, the year with the highest reported number of completed suicides was 2007 with 300 reported.

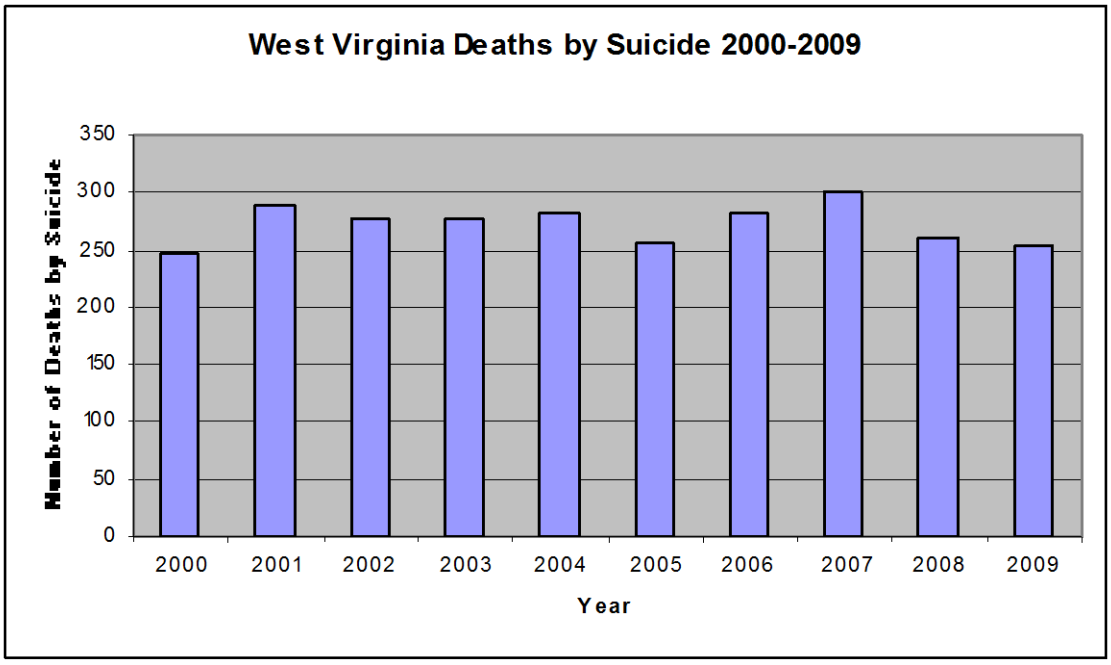


Table 1 breaks down the reported completed suicides in WV by age and gender. In 2009 there was a reported 27 deaths by suicide among the ages of 15 to 24 in WV, with a rate of 11.35, with ranked 22nd in the nation. Males accounted 93% (n=25) of deaths by suicide among this age group. The suicide rate among males of this age group for 2009 was 20.43, which ranked 15th in the nation. Among the age group of 25-64, there were a reported 178 deaths by suicide in 2009. Males accounted for 81% (n=178) of completed suicides among this age group.

[18] See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf

The male suicide rate for this age group for 2009 was 29.76, which ranked 22nd nation. Males among the age group of 65+ had the highest suicide rate in WV with a reported rate of 33.30 which ranked 22ndth in the nation. Among this age group there were a reported 46 deaths by suicide in WV. Males accounted for 89% (n=41). Among all age groups WV had a consistently higher rate of suicide than the national average.

Table 1: Completed Suicide by Age

	15-24	**Rate**	**25-64**	**Rate**	**65+**	**Rate**
Male	25	20.43 (15th)	144	29.76 (22nd)	41	33.30 (22nd)
Total	27	11.35 (22nd)	178	18.24 (21st)	46	16.00 (23rd)
US Total	4,140	9.76	24,847	15.52	5,421	14.29

Table 3 breaks down the number of suicides that were completed by firearm in 2009. In WV there were 178 suicide deaths by firearm, which accounts for a rate of 9.78. This ranked 9th in nation among firearm deaths. Among the age group of 25-64, the rate of firearm death was 11.99 (n=117), which ranked 10th in the nation. Among the age group of 65+, the rate of firearm death was 13.56 (n=39), which ranked 20th in the nation. In 2009 firearms accounted for 70% of suicide deaths in WV.

Table 3: Suicide by Firearm

	15-24	Rate (Rank)	25-64	Rate (Rank)	65+	Rate (Rank)
WV Total	20	8.32 (10th)	117	11.99 (12th)	39	13.56 (20th)
US Total	2,002	4.65	12,419	7.64	4,248	10.74

*All rates are per every 100,000 people
*All data was obtained from the CDC National Vital Statistics System Web-based Injury Statistics Query and Reporting System (WISQARS)

LGBT Youth

The Action Alliance for Suicide Prevention recently identified LGBT youth as a priority population for suicide prevention. LGBT youth are at a higher risk of attempting suicide than heterosexual youth. LGBT youth are 1.5 to 7 times more likely to attempt suicide than other youth.[19] A

[19] See http://www.sprc.org/library/SPRC_LGBT_Youth.pdf

recent study by the Suicide Prevention Resource Center found that LGBT youth are also more likely to be bullied by their peers, which increases the likelihood for attempted suicide.

Law Enforcement

Law enforcement officers are also at a heightened risk for suicide. The organization Badge of Life performed a study in 2008 that indicated that Law Enforcement officers have a suicide rate of 17.0/100,000.[20] This is higher than the national average of 11.2/100,000.[21] This study also indicated that Law enforcement are thee times more likely to die by suicide than they are to be killed by assailants.

Important Risk and Protective Factors

The *National Strategy for Suicide Prevention: Goals and Objectives for Action* discusses important factors that might increase the risk for suicide.

People with these risk factors may be more likely to engage in suicide behavior than people without them. Some risk factors may be reduced by interventions such as medications or social supports. Others, like previous suicide attempts, cannot be changed, but can alert others to an increased risk of suicide during periods of a recurrence of a mental illness or substance disorder or following a significantly stressful life event.

Risk factors generally fall into one of three categories. Biopsychosocial risk factors include issues that are related to health of the individuals or her or his family members. Environmental risk factors are generally situations in a person's environment which may increase stress or support suicidal thoughts. Finally, sociocultural risk factors are those concerns within the culture that increase suicidal thoughts or behaviors.

These three sets of risk factors are listed in the table below.

Biopsychosocial	Environmental	Sociocultural
Mental illnesses, particularly mood disorders, schizophrenia, anxiety disorders, and certain	Job or financial loss	Exposure to, including through the media, and influence of others who have died by suicide

[20] See http://www.badgeoflife.com/suicides.php

[21] See http://www.suicidology.org/c/document_library/get_file?folderId=232&name=DLFE-232.pdf

personality disorders		
Alcohol and other substance use disorders		
Hopelessness	Relational or social loss	Stigma associated with help-seeking behavior
Impulsive and / or aggressive tendencies		
History of trauma or abuse	Easy access to lethal means	Barriers to accessing health care
Some major physical illnesses		
Previous suicide attempt	Local clusters of suicide that have a contagious influence	Some cultural and religious beliefs
Family history of suicide		Lack of social support and sense of isolation

Thankfully, there are protective factors for suicide – actions which can help counter suicide risks. Protective factors are varied and address individual attitudes and behaviors as well as the environment and culture of the community.

Both risk factors and protective factors are addressed in this plan.

Protective factors include:

- Effective health care and clinical care for mental illnesses and substance abuse;
- Easy access to a variety of clinical interventions and supports, including peer support, for people seeking help;
- Restricted access to highly lethal means of suicide;
- Strong connections to family and community support; and
- Skills in problem solving, conflict resolution, and nonviolent handling of disputes.

It is essential to address and support the protective factors, as they have been helpful in preventing suicide. However, this plan cannot simply focus on protective factors alone since resistance to suicide is not permanent. The programs that support and maintain protection against suicide should be ongoing. As this plan is implemented, attention will be paid to addressing both the risk factors and the protective factors.

Plan Format

This suicide prevention plan is based on West Virginia-specific needs and resources. The format mirrors that of the *National Strategy for Suicide Prevention: Goals and Objectives for Action*. The plan identifies goals and objectives and outlines the strategies and activities to accomplish such goals.

The plan is divided into the Awareness, Implementation, and Methodology (AIM) categories of the national plan. In addition, a section is devoted to development of the infrastructure needed to oversee the plan's implementation.

The four categories are defined as follows:

- **Infrastructure** – Goals, objectives, strategies, and activities addressing the tangible framework needed to secure resources to coordinate and provide information and technical assistance to organizations, agencies, and individuals working to implement goals and objectives within the plan, and to update the plan over time.

- **Awareness** – Goals, objectives, strategies, and activities addressing increasing knowledge on a wide-scale basis.

- **Implementation** – Goals, objectives, strategies, and activities addressing the programs and activities conducted to prevent suicide.

- **Methodology** – Goals, objectives, strategies, and activities addressing program evaluation, surveillance, reporting, and research.

The final section is a document to be used to create a work plan to assure achievement.

Infrastructure

The tangible framework needed for coordination of plan implementation, providing information and technical assistance to organizations, agencies, and individuals working to implement components of the plan, and to updating the plan over time.

Goal: Develop broad-based support for suicide prevention among health care providers.

Objective: By 2015, health care providers will adopt best practices and interventions across the continuum of suicide prevention :

Activities:

- The Board of Directors of the West Virginia Council for the Prevention of Suicide will work with the executive directors and chairs of other health care organizations to develop a strategy to encourage inclusion of suicide prevention agency plans.

Goal: WVCPS will establish a foundation for the purpose of furthering and sustaining operational goals of the organization

Objective: By 2014, the Fundraising Committee of the WVCPS Board of Directors will develop a fundraising strategy.

Activities:

- The Fundraising Committee of the WVCPS will meet on a regular basis.
- Members of the WVCPS board of directors will receive training fundraising.
- Committee members will assist with development of community activities.
- Committee will engage the support of organizations and search for corporate sponsors.
- The Committee will coordinate at least one fundraising event every year.

Goal: Develop a support network for individuals who have been affected by a death of suicide

Objective: Efforts to improve services to individuals who have been affected by the death of a loved one due to a suicide will be implemented by 2012.

Activities:

- Develop and implement a training program on appropriatly supporting survivors of suicide loss for first responder and health care providers.
- Utilize a train the trainers curriculum for facilitators of support groups for individuals affected by the death of a loved one due to suicide.

Objective: By 2014, The WVCPS will establish regional suicide prevention coalitions in six regions as identified by the Governor's Substance Abuse Task Force.

Activities:

- The WVCPS will indentify current public and private infrastructure to collaborate in coalitions.
- The WVCPS will develop MOU detailing reponsibilities of WVCPS and the regional coalition.

Awareness

Increase public knowledge of suicide-related issues in West Virginia, including risks and protective factors for suicide and available prevention and intervention resources in the local community and throughout the state.

Goal: Enhance recognition and referral of at risk individuals

Objective: By 2015, the WVCPS will work with pre-existing public and private infrastructure in order to develop formal partnerships to incorporate suicide prevention activities

Activities:

- The Marketing and Awareness Committee of the Council will meet to prioritize a strategy of engagement to include: partners, mission and vision, key responsibilities of partners, and memorandums of understanding.

Objective: By 2015, the WVCPS will act as a clearing house for suicide prevention information, education in suicide assessment, and identification and promotion of protective factors for all WV *health care providers*

Activities:

- The Council will provide a link to evidence based practice, programs, and interventions as well as best practices for suicide prevention.
- The council will maintain a website for suicide prevention information.

Objective: By 2013, a campaign to increase efforts to reduce access to lethal means and methods of self-harm among people who have been assessed as at risk for suicide will be developed and implemented.

Activities:

- Develop and disseminate information to providers, communities, and individuals at risk regarding use of assessments, and statistics regarding use of medications and suicide risk.
- Collaborate with the Department of Natural Resources and / or other entities to develop and implement a public education campaign concerning safely storing and securing firearms.
- Encourage health care and behavioral health professionals to counsel families and friends about preventing access to means of suicide for persons who have attempted suicide.

Implementation

Enhancing and promoting programs, services, and activities to prevent suicide by promoting protective factors and reducing risks.

Goal: Promote evidence based practices, programs, and interventions as well as best practices for suicide prevention.

Objective: By 2015, the WVCPS will disseminate and provide technical assistance for suicide prevention practices, programs, and interventions.

Activities:

- The WVCPS will identify suicide prevention needs in the community, a specific programs that will meet those needs.
- The WVCPS will identify current resources in the community.
- The WVCPS will identify stakeholders and buy in from stake holders to implament evidence based practices, programs, and interventions.
- The WVCPS will provide consultation for the implamentation of evidence based practices, programs, and interventions.
- The WVCPS will provide monitoring and evaluation of evidence based practices, programs, and interventions that are implamented.
- The WVCPS will provide monitoring of ouctomes of evidence based practices, programs and interventions that are implamented.

Goal: Provide for the enhanced follow-services for deliberate self-harm individuals

Objective: By 2015, the WVCPS will improve access to services for identified individuals receiving services from hospital emergency departments and / or primary care clinics following a suicide attempt.

Activities:

- The WVCPS will Disseminate best-practice materials to EDs throughout the state
- Advocate for Reinforced follow-up arrangements for deliberate self-harm emergency department admissions as they are identified and responded to through existing crisis response services in providing for additional education resources and recommendation of enhance follow-up care.

Methodology

Gathering data to evalute the effectiveness of programs, activities, and clinical treatments, and conducting suicide-specific surveillance and research.

Goal: Improve the current data collect and results information system

Objective: Meet with evaluation staff to develop a system and process regarding data to be collected

Activities:

- Collect and allalyze WV county, states, and national comparable data to inform planning
- Publicly disseminate rsults through web-based efforts
- Participate in the state WVSEOW work group
- Evaluate all program activites and consumer satisfaction and disseminate the results

Glossary of Terms

Affected by suicide—All those who may feel the impact of suicidal behaviors, including those bereaved by suicide, as well as community members and others.

Best practices—Activities or programs that are in keeping with the best available evidence regarding what is effective.

Community—A group of individuals residing in the same locality or sharing a common interest.

Culturally appropriate—A set of values, behaviors, attitudes, and practices reflected in the work of an organization or program that enables it to be effective across cultures, including the ability of the program to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services.

Culture—The integrated pattern of human behavior that includes thoughts, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, faith, or social group.

Deliberate self-harm—See suicidal self-directed violence.

Evidence-based programs—Programs that have undergone scientific evaluation and have proven to be effective.

Goal—A broad and high-level statement of general purpose to guide planning on an issue; it focuses on the end result of the work.

Health—The complete state of physical, mental, and social well-being, not merely the absence of disease or infirmity.

Health Care – The care that an individual receives for physical, mental, and social wellbeing.

Intervention—A strategy or approach that is intended to prevent an outcome or to alter the course of an existing condition (such as providing lithium for bipolar disorders, educating providers about suicide prevention, or reducing access to lethal means among individuals with suicide risk).

Lesbian, gay, bisexual, or transgender—A blanket term that refers to those who identify as lesbian, gay, bisexual, or transgender.

Means—The instrument or object used to carry out a self-destructive act (e.g., chemicals, medications, illicit drugs).

Means restriction—Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Outcome—A measurable change in the health of an individual or group of individuals that is attributable to an intervention.

Postvention—Response to and care for individuals affected in the aftermath of a suicide attempt or suicide death.

Prevention—A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

Protective factors—Factors that make it less likely that individuals will develop a disorder. Protective factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Rate—The number per unit of the population with a particular characteristic, for a given unit of time.

Resilience—Capacities within a person that promote positive outcomes, such as mental health and wellbeing, and provide protection from factors that might otherwise place that person at risk for adverse health outcomes.

Risk factors—Factors that make it more likely that individuals will develop a disorder. Risk factors may encompass biological, psychological, or social factors in the individual, family, and environment.

Self-directed violence (same as self-injurious behavior)—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Self-directed violence can be categorized as either nonsuicidal or suicidal.

Stakeholders—Entities including organizations, groups, and individuals that are affected by and contribute to decisions, consultations, and policies.

Suicidal behaviors—Behaviors related to suicide, including preparatory acts, as well as suicide attempts and deaths.

Suicidal self-directed violence—Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent.

Suicidal ideation—Thoughts of engaging in suicide-related behavior.

Suicidal intent . —There is evidence (explicit and/or implicit) that at the time of injury the individual intended to kill him or herself or wished to die and that the individual understood the probable consequences of his or her actions.

Suicidal plan—A thought regarding a self-initiated action that facilitates self-harm behavior or a suicide attempt; often including an organized manner of engaging in suicidal behavior such as a description of a time frame and method.

Suicide—Death caused by self-directed injurious behavior with any intent to die as a result of the behavior.

Suicide attempt—A nonfatal self-directed potentially injurious behavior with any intent to die as a result of the behavior. A suicide attempt may or may not result in injury.

Suicide crisis—A suicide crisis, suicidal crisis, or potential suicide, is a situation in which a person is attempting to kill him or herself or is seriously contemplating or planning to do so. It is considered a medical emergency, requiring immediate suicide intervention and emergency medical treatment.

Suicide attempt survivors—Individuals who have survived a prior suicide attempt.

Suicide loss survivors—See bereaved by suicide.

Achieving the Goals of the Plan

This plan has four goals and nine objectives. It includes strategies and activities which are designed to accomplish the goals and objectives. It is a five year plan – expected to be completed or modified by 2011.

Specific timelines for objectives and activities are not listed in this plan. It is expected that major responsibility and accountability to achieve the plan will be given to the West Virginia Council for the Prevention of Suicide when it is approved by the West Virginia Department of Health and Human Resources.

The grid on the following pages is provided for use by the Council in developing a work plan.

Goals and objectives are re-stated in each of one of four categories: Infrastructure, Awareness, Implementation, and Methodology. Activities planned for each of the objectives are then listed. To the right of the activities are possible dates (year) for completion. The work plan to be developed will establish target dates for completion of each activity and could be "continuous" or a specific date.

The final column is headed "Effort Required" and is an important item to consider for achieving the plan. "Effort" will consider the resources needed – human resources, funding, physical or technical resources, and activity or project management requirements.

This Achievement Plan or Work Plan should be completed by the Council within three months of the plan's acceptance by the Department of Health and Human Resources.

INFRASTRUCTURE						
Goal: Develop broad-based support for suicide prevention among health care providers.						
Objective: By 2015, health care providers will adopt best practices and interventions across the continuum of suicide prevention						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
The Board of Directors of the West Virginia Council for the Prevention of Suicide will work with the executive directors and chairs of other health care organizations to develop a strategy to encourage inclusion of suicide prevention agency plans.						

Goal: WVCPS will establish a foundation for the purpose of furthering and sustaining operational goals of the organization						
Objective: By 2014, the Fundraising Committee of the WVCPS Board of Directors will develop a fundraising strategy.						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
The Fundraising Committee of the WVCPS will meet on a regular basis.						
Members of the WVCPS board of directors will receive training fundraising.						
Committee members will assist with development of community activities.						
Committee will engage the support of organizations and search for corporate sponsors.						
The Committee will coordinate at least one fundraising event every year.						

Goal: Develop a support network for individuals who have been affected by a death of suicide						
Objective: Efforts to improve services to individuals who have been affected by the death of a loved one due to a suicide will be implemented by 2011.						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
Develop and implement a training program on appropriatly supporting survivors of suicide loss for first responder and health care providers.						
Utilize a train the trainers curriculum for facilitators of support groups for individuals affected by the death of a loved one due to suicide.						

Objective: By 2014, The WVCPS will establish regional suicide prevention coalitions in six regions as identified by the Governor's Substance Abuse Task Force.						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
The WVCPS will indentify current public and private infrastructure to collaborate in coalitions						
The WVCPS will develop MOU detailing reponsibilities of WVCPS and the regional coalition						

AWARENESS						
Goal: Enhance recognition and referral of at risk individuals						
Objective: By 2015, the WVCPS will work with pre-existing public and private infrastructure in order to develop formal partnerships to incorporate suicide prevention activities						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
The Marketing and Awareness Committee of the Council will meet to prioritize a strategy of engagement to include: partners, mission and vision, key responsibilities of partners, and memorandums of understanding.						

Objective: By 2015, the WVCPS will act as a clearing house for suicide prevention information, education in suicide assessment, and identification and promotion of protective factors for all WV ***health care providers***						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
The Council will provide a link to evidence based practice, programs, and interventions as well as best practices for suicide prevention.						
The council will maintain a website for suicide prevention information.						

Objective: By 2013, a campaign to increase efforts to reduce access to lethal means and methods of self-harm among people who have been assessed as at risk for suicide will be developed and implemented.						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
Develop and disseminate information to providers, communities, and individuals at risk regarding use of assessments, and statistics regarding use of medications and suicide risk.						
Collaborate with the Department of Natural Resources and / or other entities to develop and implement a public education campaign concerning safely storing and securing firearms.						
Encourage health care and behavioral health professionals to counsel families and friends about preventing access to means of suicide for persons who have attempted suicide.						

IMPLEMENTATION						
Goal: Promote evidence based practices, programs, and interventions as well as best practices for suicide prevention.						
Objective: By2015, the WVCPS will disseminate and provide technical assistance for suicide prevention practices, programs, and interventions.						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
The WVCPS will identify suicide prevention needs in the community, a specific programs that will meet those needs.						
The WVCPS will identify current resources in the community.						
The WVCPS will identify stakeholders and buy in from stake holders to implament evidence based practices, programs, and interventions.						
The WVCPS will provide consultation for the implamentation of evidence based						

practices, programs, and interventions.						
The WVCPS will provide monitoring and evaluation of evidence based practices, programs, and interventions that are implamented.						
The WVCPS will provide monitoring of ouctomes of evidence based practices, programs and interventions that are implamented.						

Goal: Provide for the enhanced follow-services for deliberate self-harm individuals						
Objective: By 2015, the WVCPS will improve access to services for identified individuals receiving services from hospital emergency departments and / or primary care clinics following a suicide attempt.						
ACTIVITY	2011	2012	2013	2014	2015	**EFFORT**
The WVCPS will Disseminate best-practice materials to EDs throughout the state						
Advocate for Reinforced follow-up arrangements for deliberate self-harm emergency department admissions as they are identified and responded to through existing crisis response services in providing for additional education resources and recommendation of						

enhance follow-up care.						

METHODOLOGY						
Goal: Improve the current data collect and results information system						
Objective: Meet with evaluation staff to develop a system and process regarding data to be collected						
ACTIVITY						**EFFORT**
Collect and allalyze WV county, states, and national comparable data to inform planning						

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Publicly disseminate rsults through web-based efforts						
Participate in the state WVSEOW work group						
Evaluate all program activites and consumer satisfaction and disseminate the results						

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective actors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

BG: 21 Support of State Partners

1. **Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.**

The State values both public and private partnerships and could not have impact on the behavioral issues within West Virginia without the collaborative nature of the partners and willingness to serve the citizens of the State.

Governor's Advisory Council on Substance Abuse	Strategic plan development and implementation advisement and making recommendations to the Governor for policy changes
Governor's Regional Task Forces	Identifying community need and making local recommendations
WV Behavioral Health Advisory Council	Assures community voice in planning and program implementation
WVSEOW Membership	Described in document---determines need to help the State make data informed decisions
Bureau for Children and Families	Coordination of children's service and family preservation and system of care initiatives
Bureau of Medical Services (Medicaid)	Rate setting, service coverage for behavioral health and determining service definitions
Bureau of Public Health	Partner on related projects involving moms and babies, school wellness and physician best practices
Department of Education	Partner on administration of statewide school climate survey and implementation of regional wellness staff, implementation of behavioral health courses in schools, project launch and school based mental health services
WV State Police	Provide staffing for Synar and FDA Tobacco Programs
Benedum Foundation	Funding partner with Moms and Babies Recovery project
Department of Military Affairs and Public Safety	Partner on Justice Reinvestment Initiatives and Vivitrol Pilot in correctional facilities
WV DD Council	Coordination of best practice implementation for individuals with intellectual and developmental disabilities
WV State Medical Association	Coordinate Appalachian Addictions Conference and other prescriber education programs
WV Board of Pharmacy	Partner on the data and receipt of PDMP data
WV Higher Education Commission	Implementation of behavioral health education in higher education
State Universities	Partnership to determine behavioral health education in med schools, recruit and use of residents and physicians for MAT and other

	psychiatry services through telehealth
WV Office of Veterans Affairs	Coordination of behavioral health services
WV National Guard	Partner to provide cross-training for behavioral health and military
WV Behavioral Health Provider's Association	Work with to determine provider needs in making system improvements
WV Childcare Association	Partner for training and referral mechanisms
WV Primary Care Association	Coordination of integrated care
WV Collegiate Initiative	Infusion of prevention programs in schools
WV Perinatal Partnership	Substance use in pregnancy initiatives

2. **Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.**

   Forthcoming

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).

Members of the Council have been involved throughout the year in numerous community planning settings and venues, including but not limited to quarterly Council meetings, BRSS-TACS Team conference calls, the GACSA Regional Task Force meetings, in identifying issues and priorities which BBHHF has now incorporated into this year's plan. In addition, the Council will be given time to review and comment on the plan after it is posted on the Bureau's website during the @ two-week period in which it is also being reviewed by DHHR's Grant's Management Office. Finally, the Council Chair will once again be invited to submit a letter from the Council recommending modifications to the application and/or comments on the latest implementation report.

2. What mechanism does the state use to plan and implement substance abuse services?

Governor Earl Ray Tomblin issued Executive Order No. 5-11 on September 6, 2011, which created the Governor's Advisory Council on Substance Abuse (GACSA). Appointed council members include Cabinet level positions in the Department of Health and Human Resources, Department of Military Affairs and Public Safety, and the Department of Veterans Assistance; persons in leadership positions representing the State Police, Chiefs of Police, Sheriffs, Supreme Court, Education, WorkForce West Virginia, Behavioral Health and Health Facilities; experts from the fields of behavioral medicine, substance abuse prevention and treatment, peer and recovery supports, the faith-based and minority communities, homelessness, domestic violence prevention; and, a range of health professionals, among others. Responsibilities of the GACSA include: provide guidance regarding implementation of the Statewide Substance Abuse Strategic Action Plan; identify planning opportunities with other interrelated systems to increase both public and private support concerning substance abuse initiatives; recommend a list of priorities for the improvement of the substance abuse continuum of care; receive input from local communities throughout West Virginia; and, provide recommendations to the Governor to improve education, data needs, employment opportunities, communication, crime prevention, and other matters related to substance abuse. The six Regional Substance Abuse Task Forces met publicly every other month initially, now quarterly, to gather community input and funnel recommendations up to the GACSA, which then issues a yearly report with recommendations subsequently made to the Governor and his state agencies.

3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?

The WV Behavioral Health Planning Council had the foresight to fold in substance abuse stakeholders as far back as 2006, when it added seven seats for substance abuse, including the SSA, two people in recovery, two family members of someone with an addiction and two substance abuse providers. Substance abuse and co-occurring mental health issues are regularly discussed at quarterly Council meetings, including updates from the SSA on funding and policy issues.

There is on-going communication and regularly scheduled meetings between the Bureau for Behavioral Health and Health Facilities and the WVMHPC and the GACSA in determining need, addressing gaps in services and promoting quality outcomes for behavioral health. The Bureau continues to support the coordination of efforts among the West Virginia Comprehensive Behavioral Health Commission, the Governor's Advisory Council on Substance Abuse, the Governor's Regional Task Forces and the Mental Health Planning Council in order to support an integrated culturally diverse advisement structure.

4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?

The Bureau for Behavioral Health and Health Facilities continues to use Mental Health Block Grant to support the operational expenses of the West Virginia Mental Health Planning Council (WVMHPC). The WVMHPC maintains at least 51% consumer membership and provides input and recommendations to the BBHHF on issues facing consumers with mental health problems. The WVMHPC is comprised of consumers, families, and representatives of mental health and substance abuse providers, and key state entities including the West Virginia Department of Education, West Virginia Behavioral Health Provider Association, West Virginia Coalition to End Homelessness, the West Virginia Council for the Prevention of Suicide, Department of Juvenile Service, Department of Corrections, Bureau for Medical Services, Bureau for Children and Families, West Virginia Housing Development Authority and the Department of Rehabilitation Services..

There are vacancies for stakeholders representing older adults and families of young children. In addition, the Council does not currently have seats for agency staff from the Bureau of Public Health and the Bureau of Senior Services. West Virginia does not operate its own Insurance Marketplace but the Council also does not include a representative from the Office of the WV Insurance Commissioner's Office.

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The mission of the WVMHPC is to improve the mental health service system and function as a catalyst for change. The Council is federally mandated to review and comment on the State mental health plan, monitor, review, and evaluate allocation and adequacy of mental health block grant services, and advocate for services for individuals with mental illness and co-occurring substance abuse issues. The members of the Council and its subcommittees, including the Executive, Membership, Children and Families Services, Adult Services, Housing and Olmstead Committees, work collaboratively with the member state agencies to solicit input from the applicable stakeholders and provide input on agency priorities and plans, including but not limited to the Community Mental Health Services and SAPT Block Grant applications. The Council accomplishes this by: meeting at least quarterly in different areas of the State; developing strategies to accomplish Council goals pursuant to the federal mandate; actively participating in a wide range of state and local initiatives that impact behavioral health, homelessness, and community services; and, partnering with the WVDHHR Bureau for Behavioral Health and Health Facilities to assure the availability of person centered, high quality behavioral health services throughout the State and conducting independent assessments of need which are reported to the Bureau.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.102

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Bob McConnell	Parents of children with SED		357 Valley Point Lane Wheeling, WV 26003 PH: 304-780-3417	tdototh@msn.com
Angie Ferrari	Parents of children with SED		212 P Woodland Drive Nitro, WV 25143 PH: 304-377-9491	Afferrari@asphealthcare.com
Nancy Schmitt	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		3723 Winchester Ave Martinsburg, WV 25404 PH: 304-676-8053	nschmitt52@gmail.com
Marian Steele	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1022 Arbuckle Road Lot 11 Summersville, WV 26651 PH: 304-651-0714	mls@shsinc.org
Cathy Reed	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Rt 7 Box 480 Fairmont, WV 26554	kitcatwv@yahoo.com
Aaron Morris	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1039 Cannetton Hollow Rd Cannetton, WV 25036 PH: 304-442-4726	aaronmorris127@gmail.com
Phil Reed	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Rt 7 Box 480 Fairmont, WV 26554 PH: 304-363-5205	numbersmann@yahoo.com
David Sanders	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		350 Captiol Street Charleston, WV 25302 PH: 304-345-7312	David.H.Sander@wv.gov
James Ruckle	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		521 Jacob Street Apt 601 Charleston, WV 25301 PH: 304-542-6717	jbobruckle@yahoo.com
Billie Tharp	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		1471 Whitewater Road Summersville, WV 26651 PH: 304-618-7519	bjean0820@gmail.com
Nancy Deming	Providers	Valley HealthCare System	15 Tiger Trail, Fairmont Fairmont, WV 26554 PH: 304-363-6844	ndeming@valleyhealthcare.org
Linda Pauley	Providers		1449 Childress Road Alum Creek, WV 25003 PH: 304-283-0041	linda_pauley@yahoo.com

John Aldis	Providers	4911 River Road Shepherdstown, WV 25443 PH: 304-283-0041	jwaldis@gmail.com
Joe Cunningham	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	713 Bigley Ave Charleston, WV 25302 PH: 304-982-6217	joec.pm@gmail.com
Brandon Whitehouse	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	306 N Church St. Ripley, WV 25271 PH: 304-372-3722	bradonhwhitehouse@hotmail.com
Patrick Tenney	Family Members of Individuals in Recovery (to include family members of adults with SMI)	301 Scott Ave Morgantown, WV 26505 PH: 304-282-1278	ptenney@valleyhealthcare.org
Ted Johnson	Family Members of Individuals in Recovery (to include family members of adults with SMI)	2105 Superior Ave Charleston, WV 25303 PH: 304-746-1155	JonnelTjj@aol.com
Ardella Cottrill	Family Members of Individuals in Recovery (to include family members of adults with SMI)	1709 Clay Ave Fairmont, WV 26554 PH: 304-680-4837	Ardella.cottrill@yahoo.com
Heather Hoelscher	Providers	PO Box 1082 Parkersburg, WV 26102 PH: 304-276-8687	hahoelscher@yahoo.com
Vanessa Vangilder	Providers	326 Dutch Road Charleston, WV 25301 PH: 304-421-0915	vkvangilder@aol.com
Mark Drennan	Providers	405 Capitol Street Charleston, WV 25301 PH: 304-343-0728	mark@wvbehavioralhealth.org
Bob Musick	Providers	256 Normandy Street Morgantown, WV 26505 PH: 304-296-1731	bmusick@valleyhealthcare.org
Joyce Floyd	Providers	302 Nathan Street Apt. 29 Elkins, WV 26241 PH: 304-637-0903	floydjoyce35@yahoo.com
Margaret Taylor	Providers	1426 Kanawha Blvd Charleston, WV 25301 PH: 304-340-3553	mtaylor@wvcharleston.org
Louann Petts	Providers	1003 Edgewood Drive Charleston, WV 25301 PH: 304-341-6303	Louann.petta.ctr@ang.af.mil
Thomas Kimm	Providers	164 Goose Run Court Inwood, WV 25428 PH: 304-886-5550	tskimm@tskimm.com
Cynthia Parsons	State Employees	350 Capitol Street, Room 251 Charleston, WV 25301 PH: 304-588-5962	Cynthia.A.Parsons@wv.gov
Pete Minter	State Employees	405 Capitol Street, Suite 708 Charleston, WV 25301 PH: 304-347-7000	Pete.C.Minter@hud.gov

Carla Cleek	State Employees	State Capitol, PO Box 50890 Charleston, WV 25305 PH: 304-766-4881	Carla.B.Cleek@wv.gov
Debi Gillespie	State Employees	1200 Quarrier St Charleston, WV 25301 PH: 304-558-9800	Debi.d.gillespie@wv.gov
Beth Morrison	State Employees	350 Capitol Street, Room 350 Charleston, WV 25301 PH: 304-356-4976	Beth.J.Morrison@wv.gov
Jennifer Ballard	State Employees	1409 Greenbrier Street Charleston, WV 25311 PH: 304-558-2063	Jennifer.M.Ballard@wv.gov
Merritt Moore	State Employees	350 Capitol Street, Room 350 Charleston, WV 25301 PH: 304-558-0627	Merritt.E.Moore@wv.gov
Jane McCallister	State Employees	350 Capitol Street Room 691 Charleston, WV 25305 PH: 304-356-4575	Jane.B.mcallister@wv.gov
Elliott Birckhead	State Employees	350 Capitol Street Room 350 Charleston, WV 25301 PH: 304-356-4787	Elliot.H.Birckhead@wv.gov
Rhonda Cooper	State Employees	1740 Coonskin Drive Charleston, WV 25311 PH: 304-561-6578	cooper.e.cooper.ctr@us.army.mil

Footnotes:

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	46	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	10	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	8	
Others (Not State employees or providers)	0	
Total Individuals in Recovery, Family Members & Others	23	50%
State Employees	10	
Providers	11	
Federally Recognized Tribe Representatives	0	
Vacancies	2	
Total State Employees & Providers	23	50%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Persons in recovery from or providing treatment for or advocating for substance abuse services	5	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Ms. Victoria Jones
DHHR/Bureau for Behavioral Health
& Health Facilities
350 Capitol Street, room 350
Charleston, WV 25271

Dear Ms. Jones:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

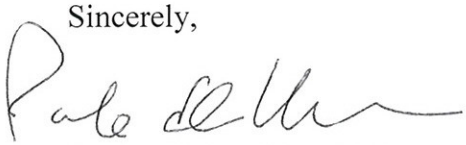
Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,



Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Peg Moss
Linda Pauley

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory